MHC
Coimisiún Meabhair-Shláinte | Mental Health Commission

Mental Health Commission

Annual Report 2016

Including Report of the Inspector of Mental Health Services

Contents

Chairman's Foreword

Strategic Development

During 2016, the Commission in association with the Executive continued its work in accordance with the Mental Health Act 2001 and under the direction of its Strategic Plan. The Commission published its fifth Strategic Plan in 2016, covering the years 2016 – 2018. It sets out our strategic vision and values and identifies the outcomes we hope to achieve in this period. The plan reflects the statutory requirements of the Mental Health Act 2001 and the Assisted Decision-Making (Capacity) Act 2015, and it accounts for the envisaged changes to the Mental Health Act 2001.

The strategic priorities of the Mental Health Commission for 2016 – 2018 are as follows:

1. Promoting the continuous improvement and reform of mental health services and standards.
2. Fostering an integrated person-centred approach for service users.
3. Encouraging the development of future-focused services.
4. Developing our people, processes and systems internally.

Policy

The national mental health policy, *A Vision for Change*, is in place since 2006. Its core concepts are recovery, person-centeredness, partnership, user and family involvement and the delivery of multi-disciplinary, community-based services.

The Commission notes the continued endeavours of the government, the statutory and independent service providers and the voluntary sector in the implementation of the policy. This report indicates that much needs to be done to ensure the delivery of consistent, timely and high-quality services in all geographic regions and across the full range of clinical programmes and age groups.

I have referred in previous years to the absence of any independent monitoring of *A Vision for Change*, a situation that has remained unchanged since 2013. I also referred in last year's report to the need to formally review the implementation of the policy ten years on from its launch. It is to be welcomed that, during 2016, the Department of Health commenced a process to complete an evidence review of best practice in the development and delivery of mental health services. Specific consideration needs to be given to Ireland's growing population and changing demographics since 2006, areas of none or partial implementation and a review of models of service.

Resources

The Commission welcomed the €35 million budget allocation in 2016 (notwithstanding the controversy over how much would actually be allocated and expended during the budgetary year) for spending on additional mental health services, with an emphasis on supporting the development of specialist community mental health teams. The Commission is cognisant that the current level of expenditure on mental health as a proportion of overall health expenditure is still less than the 8.24% target (based on 2005 figures) envisaged in *A Vision for Change*.

The Commission is conscious of the continued difficulties in maintaining and increasing staff levels in mental health services. From its inspections, it is aware of the significant effect of this on the quality and quantity of services that can be provided. Given the labour-intensive nature of mental health care services, it is imperative that this matter is addressed with urgency if full staffing of mental health teams across the country is to be achieved.

The Commission is also pleased to see ongoing progress towards decommissioning outdated and unsuitable buildings for the provision of in-patient services. The Commission emphasises the need for the continued development of community mental health services to replace traditional models of in-patient care.

Recovery-Orientated Mental Health Services

Since its establishment, the Commission has seen significant changes in the provision of mental health services, but challenges remain in terms of the delivery of high-quality, recovery-oriented services. Although staff understand the concept of "recovery," it is not evident that this translates into recovery-focused care, particularly in relation to the development of individual care plans. It is concerning that just a small minority of approved centres had individual care plans that were recovery-centred, with strong service user involvement and multi-disciplinary input.

It is encouraging that Advancing Recovery in Ireland (ARI) is well established in many Community Healthcare Organisations (CHOs) and is in progress in others. The Commission welcomes this initiative, which involves service users in their own recovery. ARI is contributing to the development of a recovery-oriented service and addressing the cultural shift in how services are delivered, away from a linear medical model towards a more holistic, bio-psychosocial one. However, a change in attitudes and behaviours is still required so that all staff delivering mental health services are trained in recovery competencies, work in partnership with service users and their families and work cohesively with other mental health professionals to provide an integrated, responsive and person-centred service that caters to the needs of individuals and their families in a timely and appropriate manner.

The Commission welcomes the appointment of a Head of Service User, Family Member and Carer Engagement, to the HSE National Mental Health Management Team and of Area Leads for Mental Health Engagement as members of mental health services area management teams.

The Commission is of the view that there needs to be an emphasis on changing the corporate culture to bring about the required systematic shift towards recovery in service provision. In this regard, it will continue to focus on the need for individualised, recovery-oriented services that place service users and family members at the centre of all activity.

Compliance

The Commission is concerned that in 2016 there was an overall decrease in compliance with statutory requirements. One reason for this may be that a standardised rating system for inspections was introduced in 2016, following a review of the *Judgement Support Framework* and the specification of clear requirements to prevent misinterpretation.

The Commission is pleased to note high levels of compliance with some standards during 2016. Of note, are standards relating to religious practice, fulfilment of rights to Mental Health Tribunal hearings, patient identification, health and safety, and food and nutrition.

During 2016, the Commission identified numerous areas of significant non-compliance. These relate to individual care planning, privacy, the availability of therapeutic activities in continuing care facilities, staff training, safety of premises, breaches of rules on seclusion, and medication management. Many of these issues have been recurring themes for a number of years and must be addressed to ensure the provision of high-quality services.

Of particular concern was the lack of compliance with the Regulation on individual care planning. In eight approved centres, not all residents had an individual care plan as required by the Regulation. Ten years since the commencement of the regulations, there is still a lack of understanding of the purpose and composition of an individual care plan. This is in spite of the definition provided in the Regulation, with additional guidance in the *Judgement Support Framework* and the Commission's *Guidance Document on Individual Care Planning Mental Health Services (2012)*.

Involuntary Admissions

In 2016, there were 2,414 involuntary admissions compared to 2,363 in 2015, representing a 2% increase. Looking at the total number of admissions for the period 2012 – 2016, there has been an incremental increase in annual admission rates, from 2,141 in 2012. While the Commission cannot identify the precise reasons for such an increase, it is worth noting that modern mental health policy and practice suggests that admission to in-patient care, especially involuntary admission, should be a last resort intervention. All community-based interventions should be considered and implemented prior to the decision to admit, whether on a voluntary or involuntary basis.

Family members continue to be the most prevalent applicant at 44% of all involuntary admissions. Looking at the longitudinal pattern the Commission is pleased to note that the rate of involuntary admissions where family members are the primary applicants has reduced from 69 % in 2007 to 44% in 2016.

Applications from the Gardaí continue to rise, with an increase from 23% in 2015 to 25% in 2016. This is a cause for concern and requires a review of the operation of the Authorised Officer Scheme, as is proposed in the Expert Group report.

Community Residences

The Commission continues to have concerns about 24-hour staffed community residences, which are providing care to a large cohort of vulnerable people with long-term mental illness. The residences have been found to be accommodating too many service users, to have poor physical infrastructure, to be institutional in nature and to lack individual care plans. A major issue is that the residences are not regulated. Although the Mental Health Act permits the Inspector to visit and inspect "any other premises where mental health services

are being provided", community residences are not subject to regulation by the Mental Health Commission.

It is recommended in the *Report of the Expert Group on the Review of the Mental Health Act 2001* that community services should be registered and inspected. The Commission is of the view that the regulation of 24-hour staffed community residences must be prioritised.

Child Admissions

A most unsatisfactory situation still prevails, whereby children are being admitted to adult in-patient units. There were 68 such admissions to 19 adult units in 2016, representing a 29.2% decrease on the number of admissions in 2015. While this downward trend is welcome, the admission of any child to an adult service is unsatisfactory. A contributory factor to the continued admission of children to adult units is a shortage of operational beds in dedicated child units. In 2016, there were 76 registered beds in HSE child units, but only 66 of these were operational. Of those operational beds, the average monthly rate of bed occupancy ranged from a low of 24% to 100%.

This matter has been a concern to the Commission for many years and needs to be addressed urgently by the Government, the Department of Health and the HSE.

Legislation

The final report of the group tasked with the review of the Mental Health Act 2001 was published in March 2015, which I alluded to in previous reports. Unfortunately, draft legislation has not been progressed to bring about the changes envisaged in the review, with one exception: the passing of legislation in March 2015 to remove the word "unwilling" from the Act. The Mental Health (Amendment) Act 2015 came into force on 15 February 2016, after which it became illegal to administer Electro-Convulsive Therapy or medication for more than three months to an involuntary patient who is unwilling to consent. This was an important advancement for the rights of service-users.

Given the length of time since the original Mental Health Act was passed (2001) and the ever-changing, modern mental health policy and practice environment, it is now a matter of urgency that the recommended legislative changes are made. Without these changes, the Act is at risk of becoming outdated and irrelevant. Ireland is now faced with a situation where mental health services catering to the majority of service users and their families are not subject to independent regulation and standards.

The Commission acknowledges the enactment of the Assisted Decision-Making (Capacity) Act 2016, particularly the powers conferred on the Commission regarding the Office of the Director of Decision Support Services.

During 2016, the Commission commenced discussions with the Departments of Health and Justice and it is expected the Commission will be in a position to progress the recruitment of the Director of the Decision Support Service in early 2017.

Conclusion

The Commission is concerned that there are serious issues to be addressed in relation to the admission of children to adult services and the shortage of operational beds for young service users.

It is also concerned about the number of vulnerable people with long-term mental illness who are accommodated in 24-hour community residences that are not subject to regulatory oversight.

Fundamentals in in-patient settings, such as individual care plans, privacy, the provision of therapeutic activities in continuing care facilities, and staff training are also areas that require urgent attention.

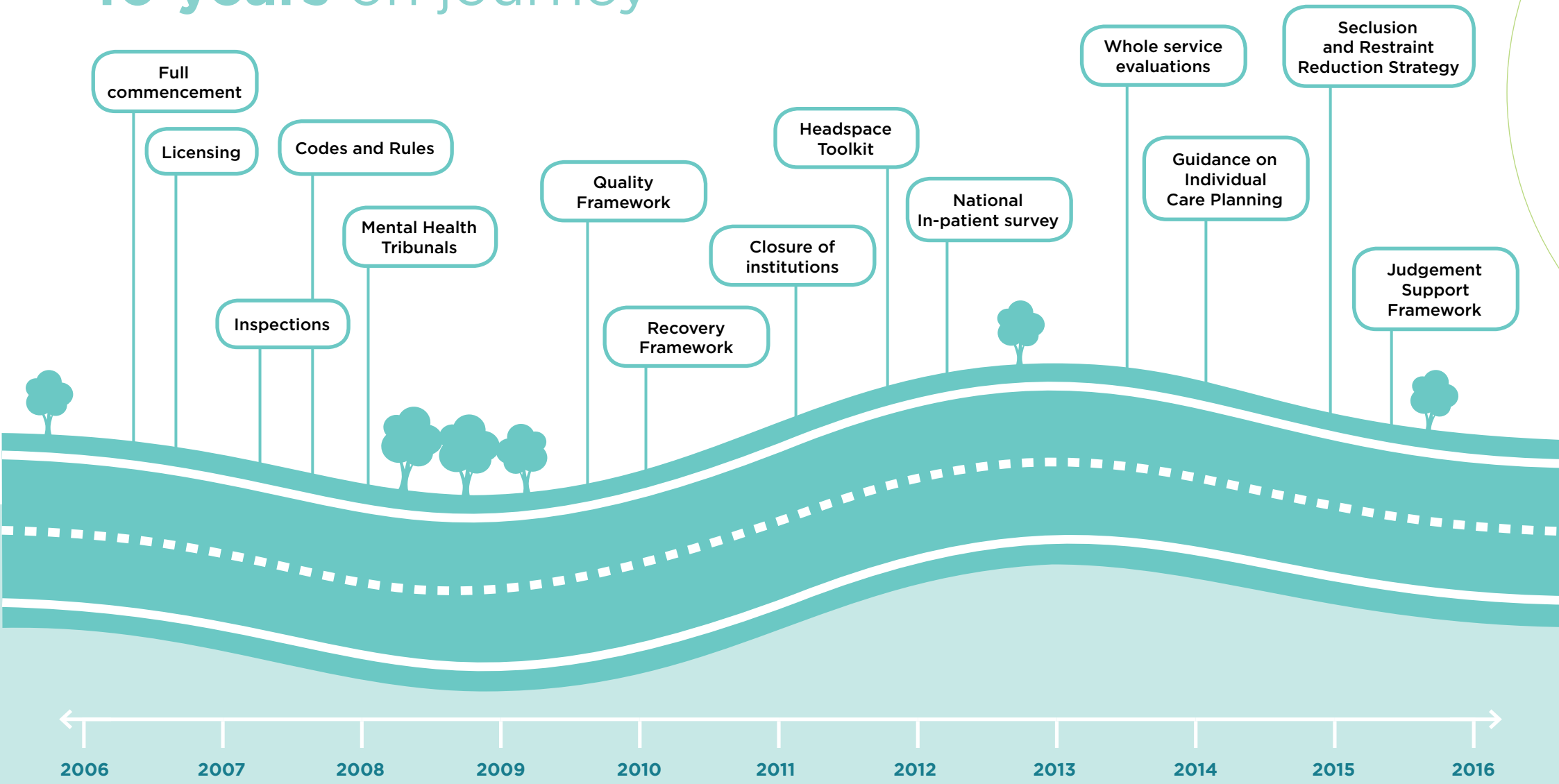
Much work remains to be done to change service culture and to refocus on the full delivery of A Vision for Change. Services must be accessible, comprehensive, responsive and timely. Now more than ever, it is necessary to address systemic issues that hamper the delivery of services and the development of newer, more appropriate ones.

Reform of the Mental Health Act 2001 is now a matter of urgency.

Finally, I want thank the members of the outgoing Commission for supporting me in my role as Chairman. I would also like to thank the Commission's Chief Executive, Patricia Gilheaney, the senior management team and all of the Mental Health Commission staff for their support and commitment.

John Saunders
Chairman

10 years on journey



Recovery

Care Planning

Quality Improvement

Chief Executive's Introduction

This year's Annual Report marks a decade following the commencement in full of the Mental Health Act 2001. Although the Commission was established in 2002, it was Ist November 2006 before our regulatory and mental health tribunal functions were commenced. Throughout this time we have worked diligently to fulfil our mandate to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to protect the interests of involuntary patients.

The strategic direction of each Board pushed the Commission forward with focuses on recovery, care planning and quality improvement. The current Board continued this trend and set out four strategic priorities for 2016-2018. We will therefore continue to strive and work towards the promotion of continuous improvement and reform of mental health services and standards; fostering an integrated, person-centred approach for service users; encouraging the development of future focused services. These priorities can only be achieved if we continue to invest in and develop our people, processes and internal systems.

This year, you will note a change in the format of our Annual Report and we hope that you find it informative. Over the last ten years we have been collecting data across all of our core activity areas. We are now at a point where we can aggregate and analyse all of this data and look at the national picture of mental health services in Ireland. This gives us a strong baseline going forward to identify risks, analyse trends and highlight areas of good practice. As we are marking ten years of activity we also identify operational milestones along the way and point you to our website for additional information. Throughout the report you will notice that we illustrate change across our range of functions since 2007. This Annual Report contains the Report of the Inspector of Mental Health Services for the calendar year 2016.

During the year we reinforced our mandate through our mission 'to safeguard the rights of service users, encourage continuous quality improvement, and to report independently on the quality and safety of mental health services in Ireland. We embarked upon major recruitment and training programmes for the appointment of panels for mental health tribunals. This occurs on a three yearly cycle and requires considerable input from the Commission team.

In July 2016 we received a request from the Department of Health to develop the Decision Support Service, under the provisions of the Assisted Decision-Making (Capacity) Act 2015. We also accepted an invitation to join an Implementation Steering Group established by the Department of Justice and Equality and Department of Health, to oversee the development of this essential service within the Commission. The establishment of the Decision Support Service is a vital component in Ireland's approach to safeguarding. We will continue in 2017 to seek the appropriate infrastructure to enable the development of this service and we believe that our experience in relation to the administration of mental health tribunals coupled with the development of codes of practice over the past decade will serve us well and assist us to prepare for the challenges that lie ahead. We will also continue to contribute as a member of the National Safeguarding Committee to lead on encouraging an organisational and societal culture which promotes the rights of adults who may be vulnerable at some point in their lives.

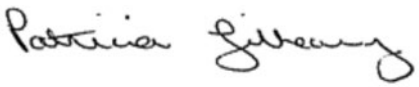
At the beginning of the year we embarked upon an independent organisation structure review. The review took place over a number of months and included the input of all staff. It is acknowledged that the original structure of the Commission was designed to make the organisation operational. While our functions have evolved since our establishment, the functional structure has remained relatively constant. The Commission has managed to meet its mandated activities in the context of a challenging operating environment and ever increasing human resource constraints over the past number of years. In December, the independent organisational review report was completed and it identified that a consequence of this operating context is that resource gaps have emerged across the organisation and some strategic development initiatives have suffered from under investment. The Commission accepted in full the findings in the independent review report and the need to significantly augment the staffing resource within the

Commission if we are to be effectively placed to control the risks to our current operations and leverage our capabilities to continue to achieve our mandate under the Mental Health Act 2001 and also establish the Decision Support Service. I look forward to progressing this issue during 2017 so that we can continue to fulfil our statutory mandate.

Every year I take this opportunity to thank my colleagues within the Commission. 2016 was particularly challenging for the reasons outlined above and none of the team was found wanting. Through their dedication, commitment and belief in what we do, they again were unfaltering in their efforts, so I extend a sincere thank you not only on my own behalf or that of the Commission, but on behalf of the people who avail of the mental health services that we strive to report on independently, and then act independently to bring about improvements; and also the many people who have their human rights upheld within the mental health tribunals processes.

Finally, I extend my thanks to John Saunders (Chairman) and the Members of the Commission and Commission Committees for their strategic direction, oversight and governance.

I look forward with vigour and optimism to 2017 and the successful attainment of the challenges that lie ahead.



Patricia Gilheaney
Chief Executive

Over the last ten years we have been collecting data across all of our core activity areas. We are now at a point where we can aggregate and analyse all of this data and look at the national picture of mental health services in Ireland. This gives us a strong baseline going forward to identify risks, analyse trends and highlight areas of good practice.

Strategic Priorities 2016 – 2018

- Promoting the continuous improvement and reform of mental health services and standards
- Fostering an integrated, person-centred approach for service users
- Encouraging the development of future focused services
- Developing our people, processes and systems internally

Our Vision

Our vision is a quality mental health service that is founded on the provision of recovery based care, dignity and autonomy for service users.

Our Mission

Our mission is to safeguard the rights of service users, to encourage continuous quality improvement, and to report independently on the quality and safety of mental health services in Ireland.

Who we are and what we do

Introduction

The Mental Health Commission is the regulator for mental health services in Ireland.

We are an independent statutory body which was established in April 2002. The core functions of the Commission came into effect following full commencement of the 2001 Act, in 2006.

The organisation's main functions are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to protect the interests of persons admitted and detained under the Act (Section 33(1) Mental Health Act 2001).

In 2016, we reinforced our mandate through our mission to safeguard the rights of service users, encourage continuous quality improvement, and to report independently on the quality and safety of mental health services in Ireland.

As a regulator, we uphold the following values:

- **Accountability & Integrity**
- **Confidentiality**
- **Quality**
- **Empowerment**
- **Recovery**
- **Dignity & Respect**

10
YEARS ON

Following the full commencement of the 2001 Act in 2006, we introduced mental health tribunals, annual regulatory inspections, and the first statutory licencing system for health services in Ireland.

We **safeguard** service user rights

- We administer mental health tribunals
- We register approved centres
- We enforce the Mental Health Act 2001
- We promote autonomous decision making

We encourage continuous **quality improvement**

- We issue guidance to services
- We inspect services
- We monitor compliance

We **report independently** on the quality and safety of services

- We monitor child admissions
- We collect and report on data

The National Picture

64 approved centres

2791 in-patient beds

92 CAMHS beds*

68 child admissions to adult units

152 in-patient deaths

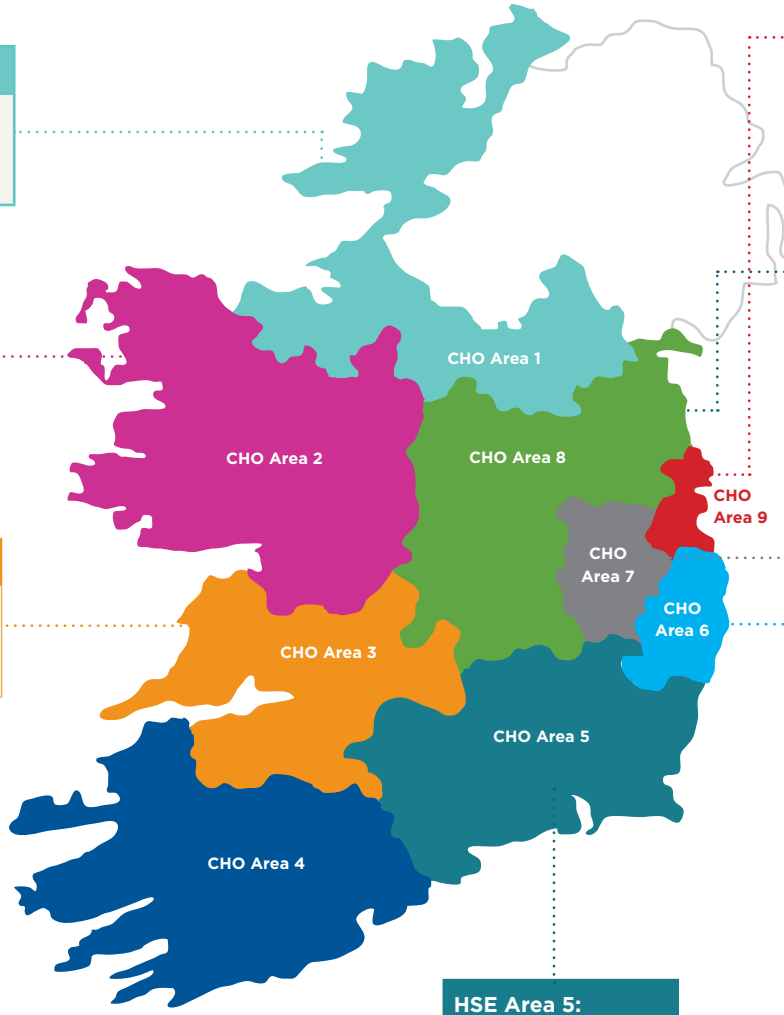
50 enforcement actions

2079 tribunal hearings

74% compliance with regulations

4,588,252 total population**

**operational beds*
***2011 census*



HSE Area 1:
Donegal, Sligo/ Leitrim/West Cavan, Cavan Monaghan

HSE Area 2:
Galway, Roscommon, Mayo

HSE Area 3:
Clare, Limerick, North Tipperary/ East Limerick

HSE Area 4:
Kerry, North Cork, North Lee, South Lee, West Cork

Independent Sector:
National coverage
CAMHS: National coverage

HSE Area 5:
South Tipperary, Carlow Kilkenny, Waterford, Wexford

HSE Area 6:
Wicklow, Dun Laoghaire, Dublin South East

HSE Area 7:
Kildare/West Wicklow, Dublin West, Dublin South City, Dublin South West

HSE Area 8:
Laois/Offaly, Longford/West Meath, Louth/Meath

HSE Area 9:
Dublin North, Dublin North Central, Dublin North West

We analyse data across HSE Community Health Organisations (CHOs), child and adolescent mental health services (CAMHS) and independent services. This allows us to analyse trends, highlight good practices and identify potential risks.

	1	2	3	4	5	6	7	8	9	Independent	CAMHS
Population	389,048	445,356	379,327	664,534	497,578	364,464	674,071	592,388	581,486	National	National
Approved Centres	5	8	4	9	6	3	3	6	7	6	5
Beds by 100,000	34.2	40.4	38.0	52.7	41.8	40.1	19.6	38.5	44.0	n/a	n/a
Regulatory compliance	69%	76%	64%	66%	72%	68%	69%	80%	73%	85%	84%
Enforcement**	5/2	3/1	4/3	10/5	8/1	0	7/2	9/3	6/4	4/3	0
Child Admissions Adult Units	4	1	4	12	10	5	3	22	7	0	n/a
Involuntary Admissions*	51.9	52.5	45.6	52.2	43.2	39.5	41.1	39.7	59.8	n/a	n/a
SU Deaths+~	8.2	3.8	5.5	6.8	6.8	4.4	3.7	3.7	4.6	n/a	n/a

Rates per 100,000 population Enforcement actions per approved centres +~Sudden, unexplained deaths.*

NB: National forensic mental health service and national intellectual disability service have not been included for the purposes of comparing data.

NB: Approved centres numbers are counted as at 31 December 2016 and do not account for closures.

THE **HIGHEST RATES** OF INVOLUNTARY ADMISSIONS WERE IN

CHO 9

AND THE **LOWEST** IN

CHO 6

THERE WERE

2414

INVOLUNTARY ADMISSIONS, AN INCREASE OF **2%** FROM 2015

WE SAFEGUARD SERVICE USER RIGHTS

We administer Mental Heath Tribunals

Involuntary admissions

Most people receiving treatment in an approved centre do so by choice. However, people with mental disorders are sometimes admitted and treated as involuntary patients. The 2001 Act provides two methods for detaining a patient who has a mental disorder:

An involuntary admission order

These are made by a consultant psychiatrist on statutory Form 6, Admission Order, which must be accompanied by an application (Forms 1,2,3, or 4) and a recommendation by a registered medical practitioner (Form 5).

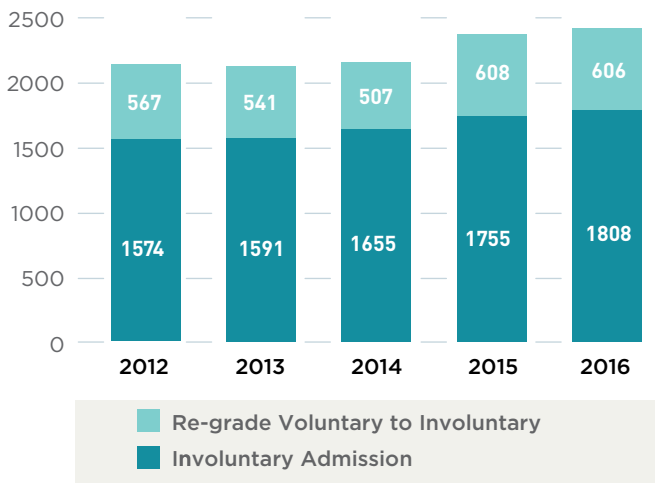
- There were 1,808 Form 6, Admission Orders, notified to the Commission in 2016.

A re-grading from a voluntary patient to an involuntary patient

In such admissions the admission order is made on statutory Form 13, Certificate & Admission Order to Detain a Voluntary Patient (Adult), signed by two consultant psychiatrists.

- There were 606 such admissions notified to the Commission in 2016.

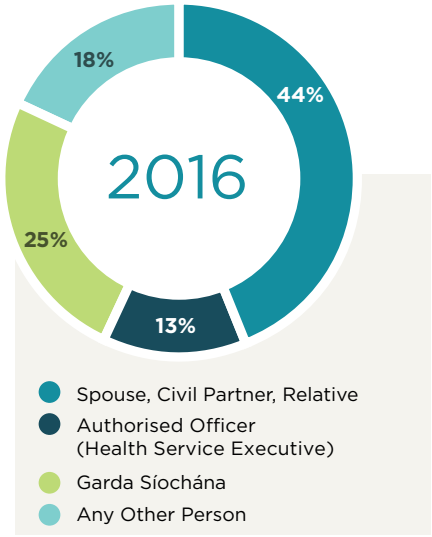
Involuntary Admissions 2012–2016



- 51 patients had 3+ admissions, an increase of 16% from 2015.

Who makes applications

As part of our analysis, we collect data on the type of applicant who applies for the admission of a person as an involuntary patient to an approved centre.



Age and Gender

In addition, we collect data across involuntary admissions by age and by gender.

- People aged between 35 and 44 years of age had the highest number of involuntary admissions, an increase from 2015 (22%).
- Those aged 65+ had a decrease in involuntary admissions, down from 18% in 2015 to 15% in 2016.
- 55% of the total involuntary admissions were men.
- In the 18-24 age group 74% of involuntary admissions were male.
- However, there were more female admissions in all age groups 45 and over.

Age	Male	Female	% gender
18-24	222	78	74% male
25-34	312	211	60% male
35-44	286	239	54% male
45-54	201	221	52% female
55-64	132	161	55% female
65+	170	181	52% female

10 YEARS ON

In 2007, 69% of applications were made by a spouse, civil partner or relative. In 2016, those applicants made up only 44%.

IN THE **18-24** AGE GROUP **74%** OF INVOLUNTARY ADMISSIONS WERE **MEN**

SPOUSE/CIVIL PARTNER/RELATIVE APPLICATIONS HAS DECREASED SINCE 2015 **(47%)**, STILL BY FAR THE **MOST PREVALENT APPLICANT** TYPE AT **44%**

IN **2016**

45%

OF ORDERS WERE **REVOKED** BEFORE HEARING

2016

WE UNDERTOOK A SIGNIFICANT **RECRUITMENT, VETTING** AND **TRAINING** PROGRAMME FOR OVER

300

INDIVIDUALS

Mental Health Tribunals

Under the 2001 Act, a person who is involuntarily admitted to an approved centre has their case independently reviewed by a mental health tribunal within 21 days of their admission or renewal order. This includes patients who were regraded from a voluntary patient to an involuntary patient. Adults receive free legal representation for their hearing during their period of involuntary detention.

Every tribunal is made up of the following:

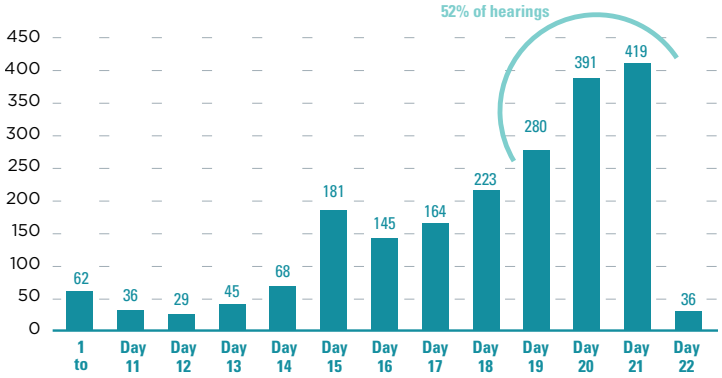
- A chairperson
- A consultant psychiatrist; and
- A lay-person

In 2016, hearings only took place outside the 21 day timeframe where the orders were extended by the tribunal, or where orders were revoked and a hearing subsequently took place at the request of the patient.

2016 key points:

- There were 2079 Mental Health Tribunal hearings in 2016, an increase of 7% from 2015.
- The majority of Mental Health Tribunals continue to take place at the end of the 21 day period.
- In 2016 45% of all orders (admission and renewal) were revoked before hearing.
- The number of circuit court appeals increased slightly from 144 to 145.

Breakdown of number of hearings over 21 day period 2016



Revocation by Responsible Consultant Psychiatrist

The consultant psychiatrist responsible for the patient must revoke an order where they become of the opinion that the patient is no longer suffering from a mental disorder.

Where the responsible consultant psychiatrist discharges a patient they must give the patient concerned, and his or her legal representative, notice to this effect.

The patient may leave the centre at this stage or stay to receive treatment on a voluntary basis.

- There were 1,648 such instances in 2016.

Tribunal Panel Members

Tribunal panel members are appointed for a three year period.

- In 2016, we undertook a significant recruitment, vetting and training programme for over 300 individuals.
- The new tribunal panels commenced on 1 November 2016.

WE SAFEGUARD SERVICE USER RIGHTS

We register approved centres

All in-patient facilities providing care and treatment to people suffering from mental illness or mental disorder must be registered by the Commission.

Registration considers information about how the facility is run, the profile of residents, how it is financed, how it is staffed and how those staff are governed. The application also seeks information about the premises and the types of services that are provided. For new applicants, the application requires information on how the facility intends to comply with regulations.

The Commission registers facilities that provide the following services:

- Acute adult mental health care
- Continuing mental health care / long stay
- Psychiatry of later life
- Mental health rehabilitation
- Forensic mental health care
- Mental health care for people with intellectual disability
- Child and adolescent mental health care

Approved centres may be registered with specific conditions relating to their compliance with Regulations.

A full list of registered approved centres is available in Appendix 1.

10
YEARS ON

In 2006, 17 approved centres were operating in inappropriate institutional settings. By 2016, only 3 remain.

64
approved centres
(up 3 from 2015)

2791
in-patient beds
(up 24 from 2015)

5
new registrations

2
closures

9
conditions on 7 approved centres

50 ENFORCEMENT ACTIONS

34% OF APPROVED CENTRES HAD ENFORCEMENT ACTIONS

4 APPROVED CENTRES HAD 4+ ENFORCEMENT ACTIONS

26% OF ENFORCEMENT ACTIONS RELATED TO CONSENT PROCEDURES

14% UNACCEPTABLE CAPAS

8% RESIDENT PRIVACY

8% STAFFING

WE SAFEGUARD SERVICE USER RIGHTS

We enforce the Mental Health Act 2001

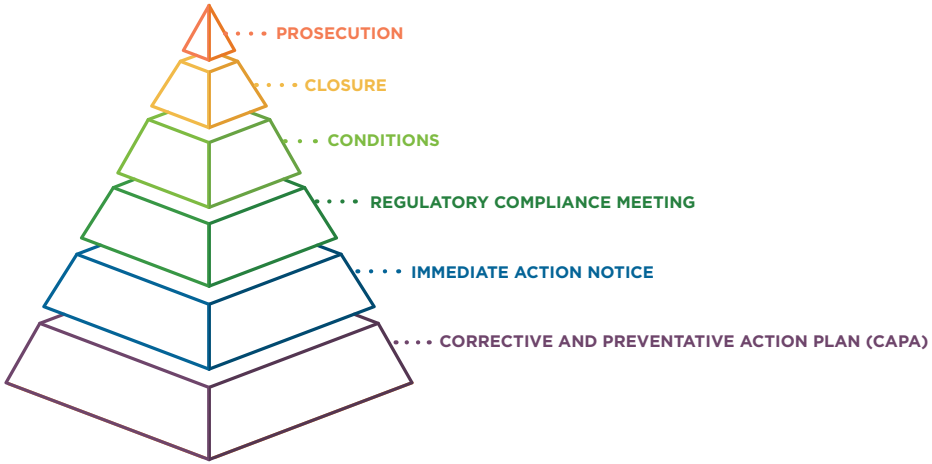
Enforcement action is taken where the Commission is concerned that an element of care and treatment provided in an approved centre, may be a risk to the safety, health and wellbeing of residents, or where there has been a failure to address an ongoing area of non-compliance.

The intention of enforcement action is not to punish services, but to push them towards high standards in the provision of mental health services.

The Commission's primary concern is always the people receiving care and treatment. It is encouraging to see significant increases in compliance in areas where focused enforcement action was taken.

A full breakdown of enforcement actions is available in the Appendix 4.

Enforcement Actions include:



WE SAFEGUARD SERVICE USER RIGHTS

Decision Support Service

Safeguarding Autonomous Decision Making that Respects People's Will and Preference

The Assisted Decision-Making (Capacity) Act 2015 (2015 Act) provides for the establishment of the Decision Support Service (DSS) within the Commission to support decision-making by and for adults with capacity difficulties and to regulate individuals who are providing support to people with capacity difficulties.

The Act significantly extends the statutory remit of the Commission to include wide-ranging regulatory and information functions for the Director of the Decision Support Service. During 2016, the Commission liaised with the Department of Health, the Department of Justice and Equality and other relevant stakeholders to begin the process of putting in place the necessary infrastructure to make the Decision Support Service operational.

The Commission has been in discussions with the relevant Government Departments to secure the necessary human and financial resources that will be necessary to progress the detailed and complex planning and operational elements that are required for the implementation of this legislation. During 2016, no additional budgetary resources were provided to the Commision for the Decision Support Service.

When the legislation is commenced, the main functions of the Decision Support Service will be:

- To provide public information and promote public awareness of the 2015 Act
- To supervise compliance by interveners with requirements of the 2015 Act
- To provide information to organisations and bodies about the 2015 Act
- To maintain a Register of agreements entered into under the 2015 Act
- To approve and draft Codes of Practice

"The Assisted Decision-Making (Capacity) Bill proposes a fundamental reform of Ireland's laws on capacity. It has been framed to meet Ireland's obligations under the UN Convention on the Rights of Persons with Disabilities.... All persons will be presumed to have legal capacity and the right to equal recognition before the law...The Bill is designed to meet the needs of older people with degenerative conditions, people with intellectual disabilities and those with mental health issues....".

Minister Kathleen Lynch,
Speech to Dáil Eireann,
3rd December 2013

2016 Key Actions:

- **In 2016, the Department of Health formally requested the Commission to begin the process of establishing the DSS.**
- **An Inter-Departmental Steering Group comprising officials of the MHC, Department of Health and the Department of Justice and Equality was established and met on five occasions.**
- **An Assistant Principal Officer was seconded from the Department of Justice and Equality to begin preparatory work for the DSS.**
- **A limited number of provisions of the 2015 Act commenced. In particular, to recruit a Director for the DSS and establish a Multi-disciplinary Working Group for a Code of Practice for Advanced Healthcare Directives**
- **The Commission engaged with the HSE National Assisted Decision Making Capacity Steering Group and National Disability Authority to provide guidance on the 2015 Act.**

WE ENCOURAGE CONTINUOUS QUALITY IMPROVEMENT

We provide guidance to approved centres

Mental Health (Amendment) Act 2015

The Mental Health (Amendment) Act 2015 came into force on 15 February 2016. The Commission issued guidance on the specific consent and capacity requirements for the administration of Electroconvulsive Therapy (ECT) to residents, and the administration of medication to involuntary patients.

Following the commencement of the Amendment Act, it became illegal to administer ECT, or administer medication for more than 3 months, to an involuntary patient if they were unwilling to consent. This was an important advancement for the rights of service users.

The Rules and Code of Practice on ECT were revised to align with international best practice.

Revised Judgement Support Framework

In 2016 the Judgement Support Framework was revised following a comprehensive review, involving consultation with a broad range of stakeholders. The framework was updated to provide clarity and transparency in relation to the inspection process and around what is needed to comply with regulations.

Mandatory Training

In 2016 we defined 5 areas of mandatory training as a minimum requirement for all healthcare professionals in approved centres. The Commission was concerned that there were consistently low levels of compliance in certain core areas and uncertainty about what was required.

- Basic life support
- Prevention and management of violence and aggression
- Fire safety
- Mental Health Act 2001
- Children First

There are practical challenges in ensuring all staff are trained in these core areas and it will take a period of time for services to become fully compliant with this requirement.

10 YEARS ON

We have provided codes of practice, rules, quality framework, judgement support framework, toolkits and e-learning materials.

We continue to promote and collaborate on legislative reform, including ongoing review of the Mental Health Act 2001.

WE ENCOURAGE CONTINUOUS QUALITY IMPROVEMENT

We inspect approved centres

The Inspector of Mental Health Services is required to visit and inspect every approved centre at least once a year. Following inspection, the Inspector prepares a report on the findings of the inspection. Each service is given an opportunity to review the report and comment on any of the content or findings prior to publication.

All reports can be found on the Commission's website at www.mhcirl.ie/Inspectorate_of_Mental_Health_Services/

On inspection, the Inspector rates compliance against:

31 REGULATIONS

6 CODES OF PRACTICE

2 STATUTORY RULES

Every non-compliant finding is assessed for risk by weighing the impact of the non-compliance against the likelihood of it recurring.

The Inspector also assess the quality of the service against the four pillars of the Judgement Support Framework:

- **Processes:** *policies, protocols & procedures*
- **Training and Education**: *staff are trained and understand what they need to do*
- **Monitoring:** *measuring, monitoring & looking for opportunities for improvement*
- **Evidence of Implementation**: *how the service demonstrates compliance*

10 YEARS ON

Since 2012, the Inspector has annually assessed every approved centre against every regulation, rule and code of practice.

We now have a standardised, consistent and transparent model of inspection.

64 APPROVED CENTRES INSPECTED

4 FOCUSED INSPECTIONS

A focused inspection may be undertaken to gather further information, or confirm that a risk has been reduced.

WE ENCOURAGE CONTINUOUS QUALITY IMPROVEMENT

We work with services to monitor compliance

The Standards and Quality Assurance Division of the Commission monitor findings made by the Inspector to identify areas of good practice and to agree plans to address non-compliances.

We monitor trends in non-compliance, to identify areas of concern where guidance might be needed, or where enforcement action is necessary.

In 2016 **63** services submitted Corrective and Preventative Action Plans, addressing between 4 and 63 individual reasons for non-compliance; a service may be non-compliant with a regulation for multiple reasons. This process was first introduced in 2015 and provides a clear measure of progress over time within services.

74%

COMPLIANCE WITH REGULATIONS

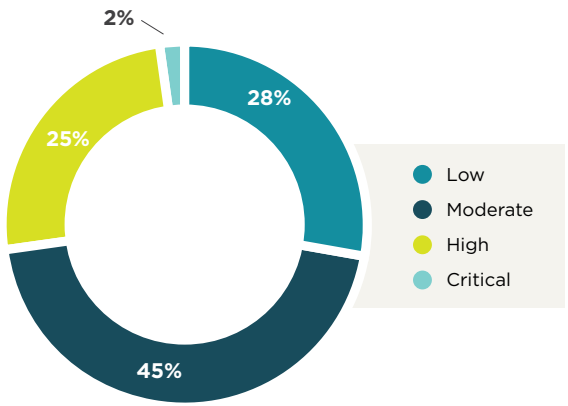
Why is Compliance dropping?

- Standardised rating system for inspections introduced in 2016 following review of the Judgement Support Framework
- Thorough and consistent inspection of all elements of the regulations, rules and codes
- Clear requirements, for example for staff training, present less room for interpretation
- Ongoing reported issues with resourcing; staff, time and funding

Key numbers:

- **74%** Compliance with Regulations (down 13% from 2015)
- **37%** Compliance with Statutory Rules (down 35% from 2015)
- **24%** Compliance with Codes of Practice (down 48% from 2015)
- **50%** Compliance with Part 4 of the Act (down 30% from 2015)
- **27%** of non-compliance were rated as high or critical risk, compared with only **18%** in 2015

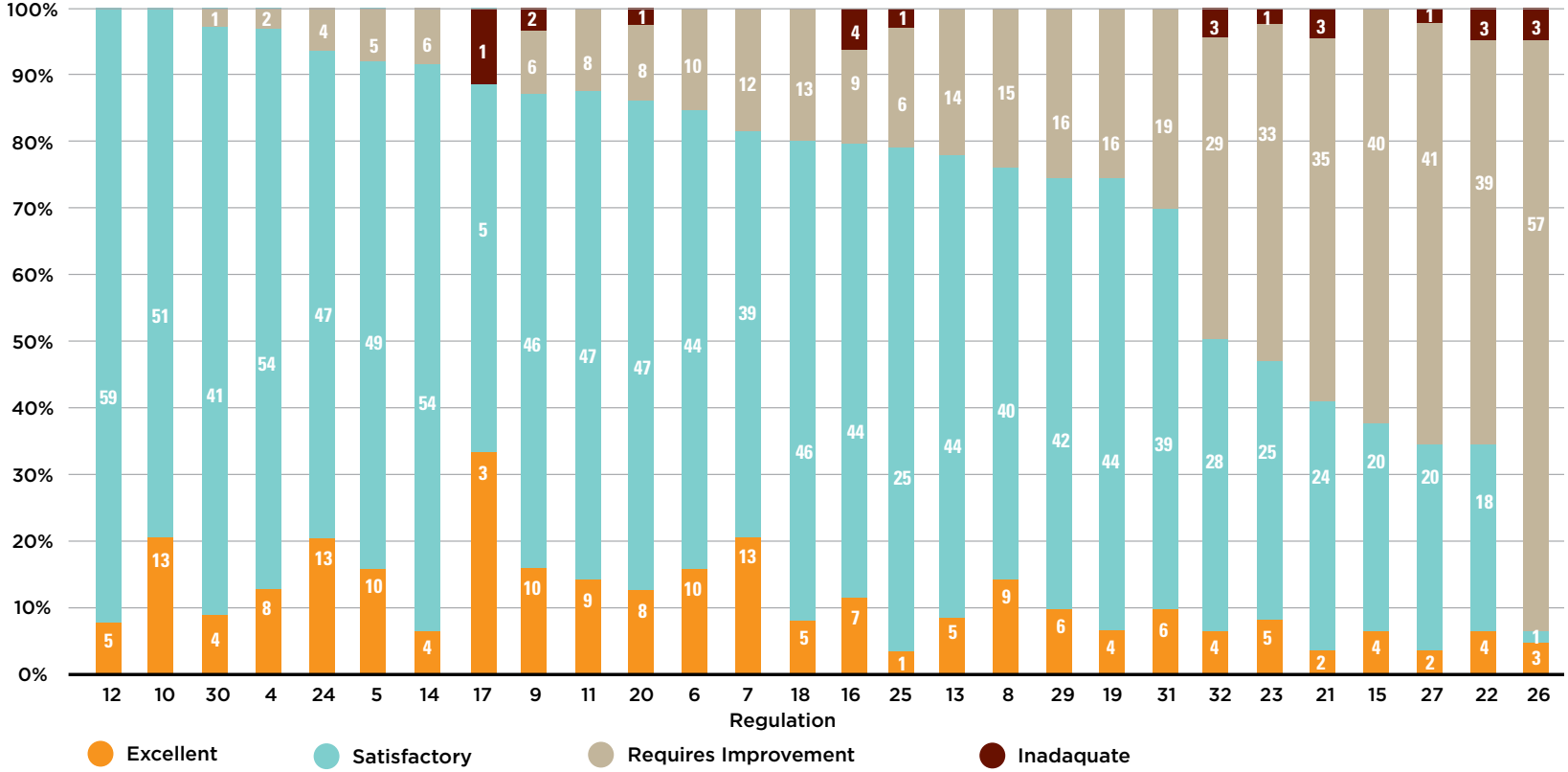
Non-Compliances Risk Rating



10
YEARS ON

In the time since full inspections commenced for all approved centres in 2012, 16 instances of full compliance with all 40 legislative requirements.

Overall Compliance and Quality Assessment with Regulations 2016 (percentages* and numbers**)



Regulation Key	
4	Identification
5	Food and Nutrition
6	Food Safety
7	Clothing
8	Residents' Property
9	Recreational Activities
10	Religion
11	Visits
12	Communication
13	Searches
14	Care of the Dying
15	Individual Care Plans
16	Therapeutic Services
17	Children's Education
18	Transfers
19	General Health
20	Information
21	Privacy
22	Premises
23	Medication
24	Health and Safety
25	CCTV
26	Staffing
27	Records
28	Register of Residents
29	Policies
30	Tribunals
31	Complaints
32	Risk Management
33	Insurance
34	Certificate

Note:

- *Percentages [y axis] are based on the number of approved centres to which that regulation was applicable
- The total number of approved centres to which regulations were applicable n = 64; with the exception of: regulation 30 n = 46; regulation 17 n = 9; regulation 25 n = 33; and regulation 13 n = 63.
- **Numbers [displayed on each bar] are the number of approved centres which were rated at that quality assessment, as per the legend.
- Regulations 28, 33 and 34 are not included because quality assessments were not completed. For other regulations, if a quality assessment was not completed the rating was included as 'satisfactory' for compliant findings and as 'requires improvement' for non-compliant findings.
- Regulation key: for full names and details of the regulations see our website.

Areas of good practice and areas of concern

Highest Compliance	Ranking	% Compliance
Regulation 10: Religion	1	100%
Regulation 12: Communication	1	100%
Regulation 30: Mental Health Tribunals	2	98%
Regulation 4: Identification of Residents	3	97%
Regulation 24: Health and Safety	4	94%
Regulation 5: Food and Nutrition	5	92%

Lowest Compliance	Ranking	% Compliance
Regulation 23: Medication	26	47%
Regulation 21: Privacy	27	41%
Regulation 15: Individual Care Plan (ICP)	28	38%
Regulation 27: Records	29	34%
Regulation 22: Premises	29	34%
Regulation 26: Staffing	31	6%

Note:

- A full breakdown of compliance by CHO/sector, including areas of good practice and areas of concern is available in the appendices.
- Regulation 30: Insurance and Regulation 34: Certificate not included

Areas of concern:

Primary reason for non-compliance

- **Medication:** Errors on the medication prescription and administration record (MPAR) record
- **Privacy:** Inadequate privacy in bedrooms and accommodations
- **ICPs:** Inappropriate goals, lack of resident involvement and insufficient MDT review
- **Maintenance of Records:** Records not being kept in good order
- **Premises:** Ligature points
- **Staffing:** Staff training

10
YEARS ON

We have established a well evidenced baseline of compliance with Regulations in Ireland. From here, we work with services towards full compliance and continued quality improvement.

WE REPORT INDEPENDENTLY ON THE QUALITY AND SAFETY OF SERVICES

We monitor child admissions

Children should not be admitted to adult mental health units except in exceptional circumstances. The Commission monitors and reports on child admissions; in particular, admissions to adult units. Over the last 10 years, we have consistently highlighted the lack of child and adolescent in-patient and day hospital facilities.

In 2016, while the number of overall child admissions increased, the number and average duration of child admissions to adult units dropped significantly.

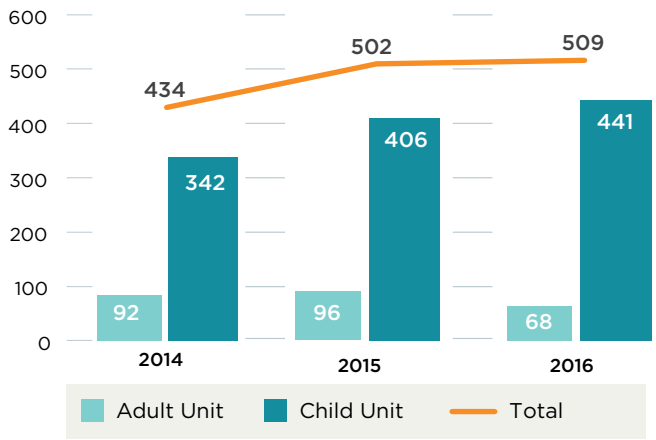
In 2016, the key results for the admission of children are presented. The results show a notable decrease, of 29%, in the admission of children to adult units in 2016 in comparison to 2015.

Although the number of admissions to adult units has decreased over the three years, the number of adult units admitting children has remained relatively consistent over the period: 20 in 2014, 21 in 2015 and 19 in 2016.

Key Figures for 2016

- **509** admissions of children
- **441** admissions of children to child units
- **68** admission of children to **19** adult units
- **1 in 7** admissions to adult unit in 2016 compared with **1 in 4** in 2015.
- **35%** of admissions to adult units resulted in the child being moved to a child unit when a bed became available. This compares with 9% in 2011.
- Average duration of admission to adult unit **6 days** in comparison to **60 days** to child unit.

Child Admissions in 2014-2016



ADMISSIONS TO ADULT UNIT

1 IN 7 IN 2016

1 IN 4 IN 2015

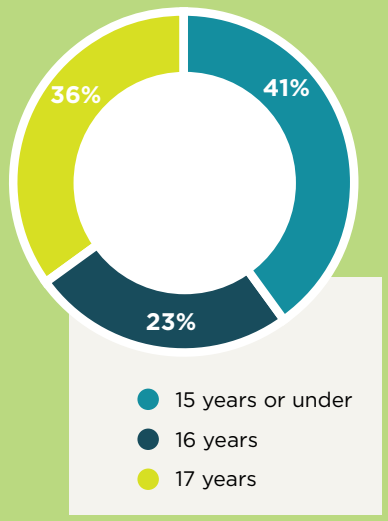
AVERAGE DURATION OF ADMISSION

ADULT UNIT

CHILD UNIT

ADMISSION BY GENDER

ADMISSION BY AGE



Age and gender

We segregate data according to age and gender. For 2016, the results highlight the number of female children admitted to mental health services. Regarding the age of child, the greatest proportion of those admitted to services were aged 15 years and under.

Admission by age

- **66%** of admissions to adult units were 17 years of age (**22%** were 16, and **12%** were 15 and under).
- **36%** of all child admissions were 17 years of age (**23%** were 16, and 41% were 15 and under)

Child involuntary admissions

Another area under quality and safety is that of the involuntary admission of children. There are provisions under Section 25 of the Mental Health Act 2001 in relation to the involuntary admission of children that require the HSE to make an application to the District Court.

- In 2016, there were **12** Section 25 Orders for involuntary admission to approved centres.
- **2** were to adult units and the remaining **10** were to child units.

Bed occupancy

In 2016, there were **76** registered beds in HSE child units, however only **66** of these were operational.

Of those operational beds, the average monthly rate of bed occupancy in HSE child units ranged from a low of **24%** to **100%**.

10
YEARS ON

In 2007, 2 out of 3 child admissions were to adult units. In 2016 this number had reduced to 1 in 7.

In 2016 19 adult units admitted children, in comparison to 32 adult units in 2007.

There were only 28 CAMHS beds in operation in 2008, this had risen to 92 in 2016.

WE REPORT INDEPENDENTLY ON THE QUALITY AND SAFETY OF SERVICES

We monitor deaths

Approved Centres are required to notify the Commission of the death of any resident of an approved centre. In addition, all sudden, unexpected deaths of any person availing of a mental health service must be notified to the Commission. This includes persons attending a day hospital, day centre, out-patient department or resource centre, and persons living in a 24-hour staffed community residence or group home.

For reporting purposes, data on deaths are categorised by the type of service reported on the death notification form which includes: approved centre (AC) in-patient deaths, deaths with a recent AC admission (within four weeks of their death), deaths with previous AC admission (admission to an approved centre more than four weeks prior to their death) and people who were availing of other mental health services (MHS). Data are also grouped into two types of deaths, expected deaths (due to an underlying medical or physical conditions) and sudden, unexplained deaths (unexpected deaths that may have been a suicide or that has occurred in suspicious circumstances as a result of violence or misadventure on the part of others or from any cause other than natural illness or disease). Death by suicide may only be determined by a Coroner's inquest; therefore, it is not possible for us to report on how many of the sudden and unexplained deaths reported in 2016 were due to suicide.

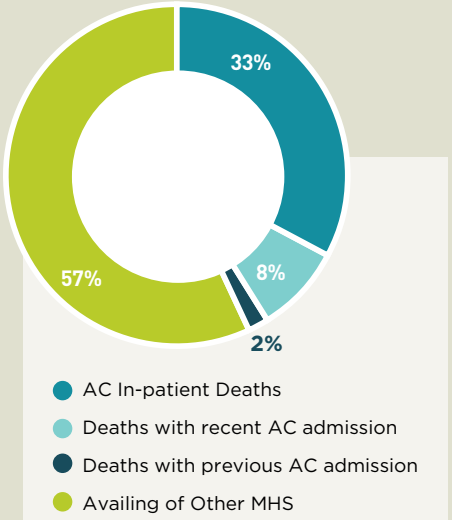
Key Figures for 2016

- The Commission received **463** death notifications in 2016 (437 in 2015)
- **57%** were sudden, unexplained deaths. (53% in 2015)
- **Over half** of all deaths were availing of other mental health services (57%)
- **1 in 3** were residents of an approved centre (33%)
- **12%** of approved centre in-patient deaths were sudden, unexplained deaths (10% in 2015)

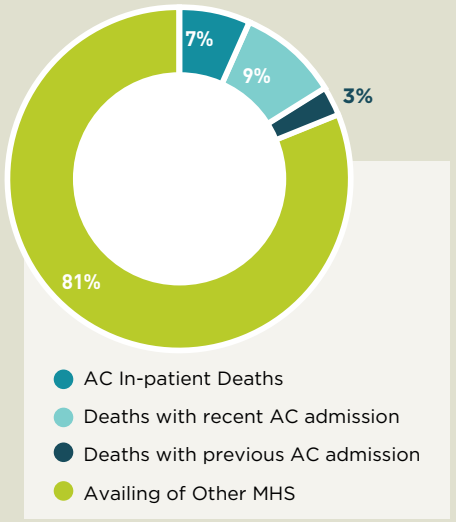
- Over half of all notified deaths were sudden, unexplained deaths (57%)
- Of these, the majority of deaths involved people who were availing of other mental health services (81%).
- 7% of sudden, unexplained deaths related to residents of approved centres. Over half of these residents were on leave, or absent without leave at the time of their death.

A further breakdown of death notification data is available in Appendix 6.

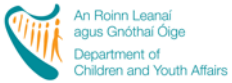
Death by service type reported



Sudden, unexplained deaths by service type



Working in Partnership



Health Service Executive

- National Office for Suicide Prevention
- Quality Assurance and Verification
- National Office for Mental Health Services
- Quality and Service User Safety Division
- National Safeguarding Committee

State Bodies

- Legal Aid Board
- Tulsa

Service Users and Carers

- Irish Advocacy Network
- Mental Health Reform
- Shine

Department of Health

- Mental Health Division
- National Patient Safety Office
- National Clinical Effectiveness Committee
- Medication Safety Forum
- National Healthcare Quality Reporting System Committee

Other Government Bodies

- Department of Children and Youth Affairs
- Department of Justice and Equality

Regulatory and Professional Bodies

- Health Information and Quality Authority (HIQA)
- Regulation and Quality Improvement Authority (RQIA) Northern Ireland

Research and Training

- St John of God Community Services
- University College Dublin
- Health Research Board
- College of Psychiatrists of Ireland

Key collaborations

In 2016 the Mental Health Commission and the Health Information and Quality Authority developed joint Draft National Standards for the Conduct of Reviews of Patient Safety Incidents. The draft standards were the first of their kind to be developed through a collaborative project between the Commission and HIQA and set out how patient safety incidents are reviewed across acute hospitals and mental health services.

Guidelines on Ethnic Minorities and Mental Health were published in 2016. They were developed by Mental Health Reform in partnership with the Mental Health Commission to provide dedicated guidelines for mental health services and staff on how to provide culturally appropriate care and supports.

Four Key Governance Pillars

(Code of Practice for the Governance of State Bodies (2016))

VALUES

Good governance supports a culture of behaviour with integrity and ethical values

PURPOSE

Clarity about mandate and clearly defined roles and responsibilities

PERFORMANCE

Defined priorities and outcomes to achieve efficient use of resources resulting in the delivery of effective public services

DEVELOPING CAPACITY

Appropriate balance of skills and knowledge within the organisation to be updated as required.

Governance & Key Enablers

Governing Body

The Members of the Mental Health Commission are the governing body for the organisation. The Commission has 13 Members including the Chairman who are appointed by the Minister for Health. Section 35 of the Mental Health Act 2001, provides for the composition of the Commission. The current Commission was appointed in April 2012 and their term will come to an end in April 2017. Members hold office for a 5 year period. Details of the Commission Members and attendance at meetings during 2016 can be found in Appendix 7.

During 2016 the Commission had three Standing Committees: the Audit Committee, Governance Advisory Committee and Legislation Committee.

Membership of these Committees and details of meetings of the Audit Committee can be found at Appendix 7.

Corporate Governance within the Mental Health Commission

The Commission is committed to reaching the highest standard of Corporate Governance. Maintaining a drive for high standards was a key feature of the work programme undertaken by Members and the Executive during 2016. The Commission's Corporate Governance Framework was developed in line with the requirements of the Code of Practice for the Governance of State Bodies (2009), which in September 2016, was superseded by the new 2016 Code.

In Quarter four of 2016, the Commission began a review of its Corporate Governance Framework to ensure it meets the standards required in the new Code. It is expected that this body of work will be completed in Quarter one 2017.

Key Governance Activities in line with the requirements of the Code undertaken during 2016

Board Effectiveness

In line with good Governance the Commission (Board) undertook a self-assessment survey during 2016 in order to refocus and ensure alignment with the organisation's strategic direction. The Commission also undertook training on the new Code of Practice in November 2016.

Code of Conduct, Ethics in Public Office, Additional Disclosures of Interests by Board Members and Protected Disclosures

The Commission's Code of Conduct was reviewed in 2016. All Members complied in full with their statutory responsibilities under the Ethics in Public Office legislation.

Protected Disclosures Act 2014 and Health Act 2007 (Part 14)

Pursuant to Section 22 of the Protected Disclosures Act 2014 and Part 14 of the Health Act 2007, the Mental Health Commission reports that there were no protected disclosures made to the Commission in 2016.

Business & Financial Reporting

The non-capital allocation to the Mental Health Commission for 2016 was €13.250 million. The outturn for 2016 in the Mental Health Commission was €13.156 million.

Key areas of expenditure related to the statutory functions as set out in the Mental Health Act 2001 including the provision of Mental Health Tribunals and inspection of Approved Centres and other locations where mental health services are provided. Additional expenditure related to staff salaries, legal fees, office rental, ICT technical support and development. Third party support contracts continue to be managed to ensure value for money and service delivery targets are met.

The accounts for 2016 have been submitted to the Comptroller and Auditor General as per Section 47 of the Mental Health Act 2001. The annual audited financial statements of the Mental Health Commission will be published on the Mental Health Commission website www.mhcirl.ie as soon as they are available.

Prompt Payment of Account legislation

The Commission complied with the requirements of the Prompt Payment of Account Legislation and paid 98.41% of valid invoices within 15 days of receipt. In order to meet this target, strict internal timelines are in place for the processing of invoices. Details of the payment timelines are published on the Commission's website.

Freedom of information

During 2016 the Mental Health Commission received 28 requests under the Freedom of Information Act 2014, of these requests, 18 were granted, 2 part-granted, 7 requests were refused and one request was withdrawn.

Data Protection

The Mental Health Commission is registered as a Data Controller, in compliance with the Data Protection Act 1988 and the Data Protection (Amendment) Act 2003.

There were 3 requests to the Commission under Data Protection legislation in 2016.

Appendix 8 provides a list of the statutory reporting requirements which the Commission met in 2016.

Risk Management, Internal Control, Internal Audit and Risk Committees

Risk Management

The effective management of organisational risk requires robust control processes to support management in achieving the Commission's objectives and in ensuring the efficiency and effectiveness of operations. In carrying out its risk management responsibilities during 2016, the Commission adhered to the three main principles of governance; openness, integrity and accountability.

OUTTURN FOR **2016** WAS

€13.156 MILLION

98.4%

OF VALID INVOICES PAID IN **<15 DAYS** OF RECEIPT

28

FOI REQUESTS RECEIVED IN **2016**

3

REQUESTS RECEIVED UNDER DATA PROTECTION LEGISLATION

ORGANISATIONAL REVIEW REPORT **ADOPTED**

100%

COMPLIANCE RATE FOR PMDS

COMMISSION RANKED

11TH OF 439

FOR ENERGY EFFICIENCY SAVING

The organisation's Risk Register for 2016 recorded details of the various key risks identified, their grading in terms of likelihood of occurring and seriousness of impact on the objectives at an organisational and team level. This register is maintained by the Senior Management Team.

The Audit Committee reviewed the Risk Register at each of its meetings in 2016.

Internal Audit and Control

The Internal control system includes all the policies and procedures (internal controls) adopted by the Commission to assist in achieving the orderly and efficient conduct of the organisation's activities including adherence to internal policies, the safeguarding of assets, the prevention and detection of fraud and error, the accuracy and completeness of the accounting records and the timely preparation of reliable financial information. Senior management has the key responsibility for ensuring an adequate and appropriate internal control system.

During Q4 of 2016 a review of internal financial controls was undertaken by Deloitte who were appointed as the Commission's Internal Auditors following a tendering process. In addition the Audit Committee and Deloitte agreed the detail of a plan of internal audit work to be undertaken during 2017 which will represent the final year of a three year internal audit planning phase.

In 2016, the Audit Committee reviewed the following internal audit reports:

- Review of Data Protection
- Information Technology General Controls
- Approved Centre – Registration and Maintenance of Register
- Review of Contracts

Audit Committee

A significant part of the work programme of the Audit Committee is the oversight role it plays in the Risk Management process. Details of the membership of the Audit Committee and meetings held in 2016 are provided in Appendix 7.

Relations with Oireachtas, Minister and Department of Health

Governance meetings with officials from the Department of Health and the Commission Executive took place in February, June and December 2016.

Remuneration and Superannuation

During 2016, the Commission finalised the Superannuation Scheme. Final documentation has been submitted for signing and adoption by the Department of Health and the Department of Public Expenditure and Reform. It is expected that the Scheme will commence in 2017.

Staff in the Commission

In 2016, the Mental Health Commission engaged in a number of recruitment campaigns led by the Corporate Services Team which saw the appointment of the Inspector of Mental Health Services and a number of Assistant Inspectors of Mental Health Services. An induction programme for these staff was led by Corporate Services, and a training programme was developed and overseen by the Director of Training & Development.

In 2016, the Director of Mental Health Tribunals and Legal Affairs position became vacant. A number of clerical officer positions also became vacant as a result of obtaining promotional grades in other organisations.

In 2016, the Commission undertook an independent organisation structure review, which included the input of all staff. The publication of the Organisation Review Report, which was commissioned in 2015, was delayed as a result of the Commission being charged with the establishment of the Decision Support Service (DSS) as provided for by the Assisted Decision Making (Capacity) Act 2015. The establishment of the DSS and the integration of same into the Commission will have significant implications for the current structure and resources of the organisation both in the design and development of the service and operationalising the service in the coming months.

The Commission adopted the Organisational Review Report at its December 2016 board meeting. The Report findings identified a number of resource gaps across the organisation and a business case will be submitted to the Department of Health in quarter one 2017 with a view to securing these essential resources.

Developing our People

Organisational learning and development continued across the Commission with the introduction of several lunchtime training sessions for staff including time management training. A wide range of training programmes were delivered including a middle management development programme.

The Performance Management Development System (PMDS) was carried out in 2016 with a compliance rate of 100%. The PMDS process ensures staff roles are aligned with the Commission's goals, staff feel valued for their hard work and their contributions are acknowledged.

The Commission also continued to promote health and wellbeing programmes for staff which commenced in 2015. One of the key health and wellbeing initiatives was the introduction of an Employee Assistance Programme.

Supports for Staff with Disabilities

The Commission provides a positive working environment and, in line with equality legislation, promotes equality of opportunity for all staff.

The National Disability Authority (NDA) has a statutory duty to monitor the employment of people with disabilities in the public sector each year. Staff census update forms were made available to all staff in order to update the record on the number of staff with disabilities in the Commission. The Commission's census results were included in a report published by the National Disability Authority (NDA).

It is the policy of the Mental Health Commission to ensure that relevant accessibility requirements for people with disabilities are an integral component of all Commission processes.

In line with the Disability Act 2005, the Commission has in place an Access Officer. The Access Officer is responsible, where appropriate, for providing or arranging for and coordinating assistance and guidance to persons with disabilities accessing the services provided by the Commission.

Tobacco Free Campus

We are committed to reducing the use of tobacco and its harmful health effects. In order to implement national policy objectives (Healthy Ireland) we have adopted a tobacco free building policy. In addition, the Commission's Employee Assistance Programme provides information on how to obtain help to quit smoking.

Management of Contractors/Service Suppliers

An extensive body of work was undertaken from Q2 to Q4 2016 focused on the selection, vetting and training of over 300 panel members for mental health tribunals as per the statutory requirements of Section 33(3)(a)(b) of the Mental Health Act 2001. Mental Health Tribunal panel members are appointed to provide services for a three year period. The term of the new panels commenced on 1st November 2016.

Information Communication Technology (ICT)

In 2016, following a tendering process the Commission awarded a tender for Information Technology Managed Support Services and a re-design of the ICT systems across the organisation. Work began on the project design in Q4 2016 and an extensive work plan will be rolled out in 2017 focused on further design elements and implementation.

In addition in 2016, the online payment system used by Mental Health Tribunal Panel Members and Commission staff was reconfigured from a system supported by a third party provider to an in-house system.

Health and Safety

The Commission is committed to ensuring the well-being of its employees by maintaining a safe place of work and by complying with the regulations and orders under the Safety, Health and Welfare at Work Act, 2005.

Energy Reporting

The Public Sector has been challenged to reach verifiable energy-efficiency savings of 33%. This target requires commitment at the highest level of management and the involvement of all public sector staff.

The Commission has been working with the Sustainable Energy Authority of Ireland (SEAI) since taking on this challenge in early 2014 when we were required to submit all of our energy data as far back as 2009. In 2016 we exceeded the target of 33% set by SEAI by 6.4%. To put this into perspective, the Commission has been ranked 11th out of 439 public sector bodies.

In 2016, the Commission consumed 175,364.47kWh of energy, consisting of 143,151kWh of electricity and 32,213.47kWh of Kerosene. This is a decrease in energy consumption of 24.3% compared to 2015 and 57.3% compared to the Comission's 2009 baseline. However, due to building renovations in 2016, our base level of heating usage was reduced and there was a reliance on space heating. The Commission expects to return to a normal pattern of heat usage in 2017. It is anticipated that, because of the enhancements which have been made to the building structure, the overall level of energy required to provide heating and lighting to the building will be reduced.

The Commission remains determined to maintain the energy-efficiency savings of 33% until 2020.

One of the key health and wellbeing initiatives was the introduction of an Employee Assistance Programme...

Mental Health Commission

Report of the Inspector of Mental Health Services

2016

Contents

Inspector of Mental Health Services - 2016 Key Findings

- It is evident that most services are working hard to be compliant with Regulations, Rules and Codes of Practice for approved centres.
- It is encouraging to see programmes that increase service user involvement and recovery being rolled out nationally.
- Although most staff in approved centres are able to articulate a recovery model of care, this is not always evident on the ground. In many centres, service users have no input into their individual care plans. An attitudinal change is required within the mental health services about individual care planning.
- There was inadequate provision of multi-disciplinary team input and therapeutic services and programmes in continuing care approved centres
- There was extensive non-compliance with privacy and dignity. Inspectors encountered examples of torn or absent privacy curtains around beds, broken locks on toilet doors, and no facilities to make a private phone call. Lack of respect for dignity was also demonstrated in the state of accommodation offered to service users in some approved centres. Some were dirty and lacked basic cleaning and maintenance.
- There are serious concerns about the use of seclusion in approved centres. These include the reasons for secluding service users, lengthy periods of time that a service user is in seclusion, the use of seclusion as punishment, and lack of efforts to reduce the use of seclusion and restraint.
- There is a lack of regulation of community residences. This is putting 1,355 vulnerable adults at risk of abuse, not receiving adequate mental health care and physical care, living in inadequate accommodation and losing autonomy. There are 122 24-hour supervised residences; 46% of them had more than ten people living in them, perpetuating institutionalisation.
- There is inadequate provision of on-call emergency child and adolescent services in many parts of the country.
- There was a drop in the admission of children to adult approved centres from 96 in 2015 to 68 in 2016.

Report of the Inspector of Mental Health Services

INTRODUCTION

The functions and duties of the Inspector of Mental Health Services are set out in sections 51 and 52 of the Mental Health Act 2001 ("the Act"). The Act includes a provision to visit and inspect every approved centre at least once in each year and to furnish a report in writing to the Mental Health Commission on the compliance by approved centres with any Code of Practice, Regulations made under section 66 of the Act, Rules made under sections 59 and 69, and the provisions of Part 4 of the Act on Consent to Treatment. Approved centres are hospitals or other in-patient facilities for the care and treatment of people experiencing a mental illness or mental disorder and which are registered with the Mental Health Commission.

The Inspector must also carry out a review of the mental health services in the State and furnish a report to the Mental Health Commission. This review must include: (a) care and treatment given to people receiving mental health services; (b) anything that the Inspector has ascertained in the approved centre or other mental health services; (c) the degree to which approved centres are complying with codes of practice; and (d) any other matter that the Inspector considers appropriate that have arisen from the review.

Inspections are carried out to determine compliance with Mental Health Act 2001 (Approved Centres) Regulations 2006[1] ("the Regulations"), Rules[2] and Codes of Practice[3] and any other issues relating to the care and treatment of service users in the approved centres (these documents may be found on the Mental Health Commission website: http://www.mhcirl.ie). The Inspector may also inspect any other service, where mental health services are being delivered under the direction of a consultant psychiatrist.

The *Judgement Support Framework* is a guidance document to assist approved centres to comply with the Regulations and Part 4 of the Mental Health Act 2001. The *Judgement Support Framework* also promotes continuous improvement of the quality of services provided to service users of approved centres. The *Judgement Support Framework* provides clarity and transparency in relation to the inspection process. It is also available on the Mental Health Commission website.

INSPECTIONS IN 2016

In 2016, a total of 64 approved centres were inspected by the Inspector of Mental Health Services and her inspection team. All inspections of approved centres in 2016 were unannounced.

Other mental health services, including 24-hour supervised residences, were not inspected in 2016 due to lack of staffing resources in the inspectorate team.

The Inspector, with the Chief Executive of the Mental Health Commission and the Director of Standards and Quality Assurance, met with the management teams of all Community Healthcare Organisations (CHOs) and with the providers of independent mental health services. Reports of the findings from these meetings are available on the Mental Health Commission website.

The Inspector had two meetings with the Irish Advocacy Network and also met with the carers and friends of the Central Mental Hospital and St. Joseph's Intellectual Disability Service.

1 *Mental Health Act 2001 (Approved Centres) Regulations 2006 (S.I. No. 551 of 2006)*

2 *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint. Mental Health Commission Rules Governing the Use of Electro-Convulsive Therapy (ECT). Mental Health Commission*

3 *Code of Practice relating to Admission of Children under the Mental Health Act 2001. Mental Health Commission*
Code of Practice on the Use of Physical Restraint in Approved Centres. Mental Health Commission
Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting. Mental Health Commission
Code of Practice on Admission, Transfer and Discharge to and from an approved centre. Mental Health Commission
Code of Practice: Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities. Mental Health Commission
Code of Practice on the Use of ECT for Voluntary Patients. Mental Health Commission Code of Practice on the Use of Physical Restraint. Mental Health Commission

COMPLIANCE WITH LEGISLATIVE REQUIREMENTS IN APPROVED CENTRES

Individual Care Plans

The Regulations for approved centres require that each service user in an approved centre has an individual care plan. Regulation 15 defines an individual care plan and each individual care plan must contain the elements described in the definition:

A documented set of goals developed, regularly reviewed and updated by the resident's multi-disciplinary team, so far as practicable in consultation with each resident. The individual care plan shall specify the treatment and care required which shall be in accordance with best practice, shall identify necessary resources and shall specify appropriate goals for the resident. For a resident who is a child, his or her individual care plan shall include education requirements. The individual care plan shall be recorded in the one composite set of documentation.

The HSE describes an individual care plan thus:

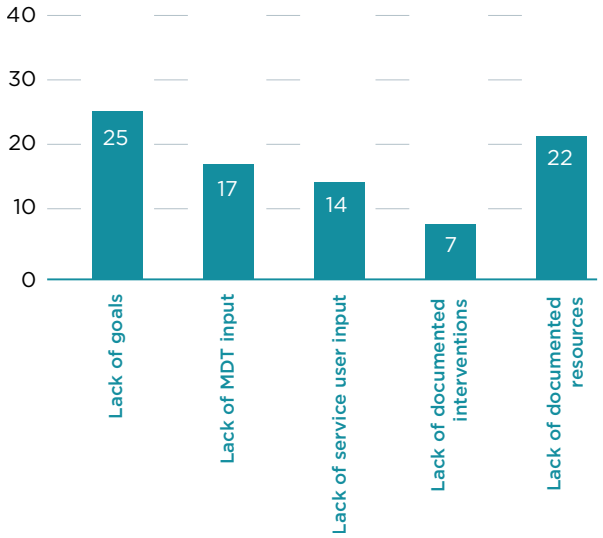
An individual care plan is a treatment plan agreed between the service user and the Mental Health Team on what will be done to address the service user's mental health difficulties. A key worker is allocated to work with the service user to develop a plan of care that outlines how the service user and mental health team can work together to build on strengths and address the difficulties[4].

The Mental Health Commission issued guidance to help mental health services in developing and maintaining individual care plans[5]. However, there have been challenges in turning care planning into a live, recovery-focused, and fully participative process. While many staff, including consultant psychiatrists, are aware of the concept of recovery, this does not translate into recovery-focused care plans in the majority of approved centres.

Only 38% of approved centres were compliant with the Regulation on individual care planning.

Only 38% (n=24) of approved centres were compliant with the Regulation on individual care planning. In eight approved centres, not all service users had an individual care plan as required by the Regulation. This is of major concern. The Inspector found that there was a basic lack of understanding of the purpose of an individual care plan and what an individual care plan should consist of, despite the definition provided in the Regulation, the *Judgement Support Framework* and the Guidance Document on Individual Care Planning Mental Health Services.

Reasons for non-compliance with individual care plans



4 *http://www.hse.ie/eng/services/list/4/Mental_Health_Services/dsc/dubwestsouth/help/careplan.html*

5 *Guidance Document on Individual Care Planning Mental Health Services. Mental Health Commission 2012*

80%

COMPLIANCE WITH THERAPEUTIC SERVICES AND PROGRAMMES

In approved centres that cared for service users who were long stay in hospital (22), 33% did not have adequate access to therapeutic services and programmes. Some of these continuing care centres provided no access to any therapeutic programmes. Multi-disciplinary input in many continuing care approved centres was limited."

Of great concern is non-compliance due to the lack of service user involvement in their own care plan.

Approved centres often do not see the individual care plan as the basic building block of service user care, treatment and recovery. This has resulted in care plans being meaningless and irrelevant.

There were four approved centres whose individual care plans were rated excellent on quality assessment. Their individual care plans were recovery-focused, with strong service user involvement and multi-disciplinary input.

Therapeutic Services and Programmes

Therapeutic services and programmes are of great benefit to the service user and must be part of a treatment programme offered in approved centres. Therapeutic services and programmes can be individual on a one-to-one basis or they can happen as part of group therapy. Examples of therapeutic services and programmes include relaxation, dialectical behavioural therapy, cognitive behaviour therapy, psychoeducation, activities of daily living training and family therapy. The provision of therapeutic services and programmes must be based on assessed need. These therapies can be used in conjunction with medication for treatment of a mental illness. Regulation 16 states that there must be access for the service user to therapeutic services and programmes in accordance with their individual care plan and that these programmes and services shall be directed towards restoring and maintaining optimal levels of physical and psychosocial functioning of a service user. In 2016, 80% (n= 51) of approved centres were compliant with this regulation. Despite difficulties in staffing, the majority of approved centres were providing access to individual and group therapies. Seven approved centres were deemed excellent in the provision of therapeutic services and programmes on quality rating.

> There is lack of understanding in many approved centres that it is the resident's care plan, that the resident should be at the heart of care planning and that the goals are their goals.

In approved centres that cared for service users who were long stay in hospital (22), 33% did not have adequate access to therapeutic services and programmes. Some of these continuing care centres provided no access to any therapeutic programmes. Multi-disciplinary input in many continuing care approved centres was limited. Priority appeared to be given to acute approved centres, leaving continuing care units poorly resourced with multi-disciplinary team members to provide therapeutic services and programmes.

Privacy and Dignity

Regulation 21 states that the registered proprietor shall ensure the service user's privacy and dignity is appropriately respected at all times.

The intention of this Regulation is to make sure that people using the service are treated with respect and dignity. To meet the requirements of the Regulation, mental health care providers must make sure that they provide care and treatment in a way that preserves service users' dignity and treats them with respect at all times. This includes making sure that people have privacy when they need and want it, treating them as equals and providing any supports they might need to be autonomous and independent.

The environment in which care is delivered has a significant impact on promoting dignity, and there are factors at both the organizational level and the individual service/practitioner level that can be implemented to ensure the achievement of dignified care. Of approved centres, 59% (n=38) were non-compliant with this Regulation. The main reasons for non-compliance were environmental difficulties, such as lack of privacy curtains around beds and on observation panels in bedroom doors, inability to make a phone call in private and absence of locks on toilet doors. In a number of approved centres, service users could be observed from public areas when in bedrooms and in garden areas. One approved centre had a public address system to summon service users for groups and medication administration. Doors to bedrooms were locked during the day in a small number of approved centres, which meant that the service users could not access their personal areas or possessions.

> How a person is treated in an approved centre is just as important as the treatment itself.

Most deficiencies outlined above are easily rectifiable: cordless phones, curtains around beds, locks on toilet doors, a premises that is clean and well maintained. The fact that these have not been addressed suggests that there is a cultural lack of awareness of service users' right to privacy and dignity in some approved centres. It is important to note that inspectors found that in the vast majority of approved centres, the nursing staff treated service users with respect and kindness.

> The lack of provision for privacy in 59% of approved centres was unacceptable.

Premises

Sixty-six percent (n= 42) of approved centres were non-compliant with Regulation 22 on premises. The reasons included poor maintenance, lack of cleanliness and the presence of ligature anchor points. There is no excuse for a lack of cleanliness and poor maintenance of buildings. Cracked tiles, peeling plaster, broken toilet door locks, inadequate lighting and ventilation, poor storage of clinical waste and dirty laundry were among the reasons for non-compliance.

A number of new approved centres had been constructed in recent years and the standard of accommodation of these centres was very high. Service users had single en suite rooms and there was adequate communal and therapeutic space and ready access to safe outside space. However, some approved centres were unsuitable buildings for the care and treatment of people with mental illness. Some had little or no access to outside space and there was lack of communal or therapeutic space. It is noted that the HSE has submitted plans to the Mental Health Commission, at various stages of development, for new purpose-built units for these approved centres. However, progress is slow.

34%

COMPLIANCE WITH PREMISES

The reasons included poor maintenance, lack of cleanliness and the presence of ligature anchor points. There is no excuse for lack of cleanliness and poor maintenance of buildings."

6%

COMPLIANCE WITH STAFFING

Approximately 41% of approved centres had ligature points. Ligature points can be defined as any fixed point which a ligature can be tied to, wedged around or behind, or held in place by any means that enables the ligature to bear the weight, wholly or partially, of a person[6]. In-patient suicide comprises a proportionately small but clinically important fraction of suicide. The most common ligature points seen on inspection were doors, hooks, exposed pipes, handles and windows, all of which have been used in in-patient suicides. Ligature audits should be completed on every room or area where a service user can be left unattended or unobserved by staff.

Staffing

Adequate staffing of mental health services was a major difficulty throughout 2016. Staffing of approved centres is inspected under Regulation 26. Ninety-four percent (n=60) of approved centres were non-compliant with staffing. In these approved centres, the training of staff was inadequate. The Mental Health Commission issued guidance in 2016 that in order to be compliant with this Regulation, all staff must be trained in Basic Life Support, fire safety, prevention and management of violence and aggression and the Mental Health Act. Approved centres struggled to provide this mandatory training of staff.

It was frequently cited that the shortages of nursing staff meant that it was difficult to release staff for training. While records of nursing staff training were usually available, it was a challenge to obtain records of medical and health and social care professional training in these areas.

Difficulties in keeping approved centres adequately staffed with nurses was evident, with agency nurses and overtime being used to fill gaps. In some approved centres, consultant psychiatrists and non-consultant hospital doctors were agency staff. There were gaps, too, in health and social care professionals, with lack of access to multi-disciplinary team input for service users. Maternity leave was not usually covered, which left vacancies for up to one year with no cover.

The training of staff was inadequate...Approved centres struggled to provide this mandatory training of staff.

6 *Care Quality Commission 2015*

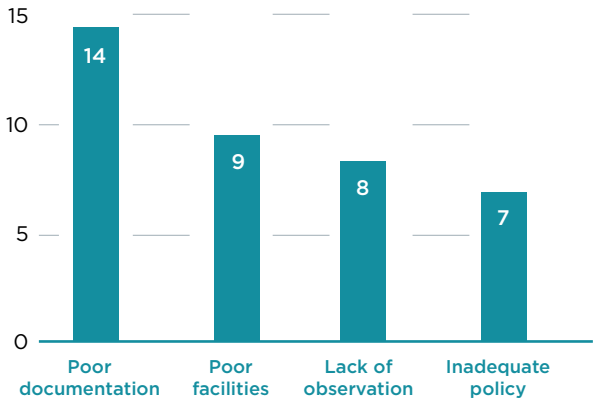
Seclusion

Seclusion occurs when a service user is involuntarily confined in a room or area and is physically prevented from leaving, usually by a locked door. The seclusion room is usually bare apart from a special mattress. Heat, light and ventilation are controlled from outside the room. The use of seclusion in psychiatric in-patient units is controversial and is highly regulated. The use of seclusion in Ireland is governed by Rules, which are secondary legislation. Twenty-five approved centres used seclusion.

In total, 85% of approved centres that used seclusion were non-compliant with the Rules Governing the Use of Seclusion.

The following are the main reasons why approved centres were non-compliant with the Rules in 2016.

Reasons for non-compliance with Rules on Seclusion



The primary goal of seclusion in in-patient psychiatry is to maintain the safety of everyone in the treatment environment. It is not a treatment in itself. Seclusion can be seen as a negative experience by individuals and be very hard to come to terms with. Because risks to service users can be severe, such as re-traumatization of people who have a history of trauma, loss of dignity, and damage to therapeutic relationships, some clinicians advocate the complete elimination of seclusion. However, failing to use seclusion in emergency situations can also result in adverse outcomes to the individual or to others in the environment. Over the past decade, a clear consensus has emerged that restraint and seclusion are safety interventions of last resort and that the use of these interventions can and should be reduced significantly. The Mental Health Commission is committed to the reduction of both the frequency and duration of seclusion and restraint episodes in approved centres and in 2014 developed a strategy for reduction of seclusion and restraint[7].

It is of interest that some approved centres catering for acutely ill service users do not have seclusion facilities and have not requested them, whereas other approved centres seclude service users for lengthy periods of time.

7 *Seclusion and Restraint Reduction Strategy. Mental Health Commission December 2014*

IT IS **ETHICALLY UNACCEPTABLE** THAT SECLUSION IS USED AS A PUNISHMENT

In 2016, 12 approved centres notified the Inspector of seclusion exceeding 72 hours. The length of time a service user spent in seclusion beyond 72 hours varied but ranged between 74.29 hours to 1,916.30 hours."

In practice, the decision to use seclusion should only be made where the balance between the potential risks of seclusion and any other intervention, such as prolonged physical restraint, indicates that it would be safer to use seclusion. There must be robust assessment of risks, which must take into account all available information.

Reasons for not using seclusions may include better staffing levels, more reliance on emergency medication, more staff training, more use of physical restraint or use of alternative strategies in dealing with violent and aggressive behaviour.

Seclusion should only be used for the shortest time. Approved centres must inform the Inspector if seclusion is extended beyond 72 hours.

Lengthy periods of seclusion are counter-therapeutic. During seclusion, the service user has no social interaction apart from nursing and medical staff doing checks and he or she is constantly observed. Service users are sometimes dressed in refractive clothing, which is a dress made of safety material and compromises patients' dignity.

The Inspector was very concerned that in one approved centre, the length of time a service user was in seclusion was dependant on that person expressing remorse or taking responsibility for behaviour that had occurred as part of their illness.

To all intents and purposes, it is solitary confinement, with no distractions, no therapy and no recreational activities.

Compliance with Part 4 of the Mental Health Act

Section 60 of Part 4 of the Mental Health Act 2001 specifies that the administration of medicine to an adult patient who is detained for longer than three months cannot be continued unless the patient gives consent in writing or the medicine is approved by the treating consultant psychiatrist and authorised by another consultant psychiatrist, on a Form 17 (Administration of Medicine for More Than 3 Months Involuntary Patient (Adult) – Unable to Consent). Compliance with Part 4 of the Mental Health Act is assessed during inspections.

In 2016, 50% of approved centres where Section 60 was applicable were non-compliant. In 79% of these approved centres, failure to assess the capacity of the patient to consent to treatment was the reason for non-compliance.

Assessment of the capacity to consent to treatment is an important legal and ethical issue. Providing treatment against the wishes

of a patient who is capable of consenting to treatment violates the principle of patient autonomy and can often violate physician beneficence. Accurate assessment of the patient's capacity to consent is therefore most important for decisions regarding psychiatric treatments which may have severe side-effects[8]. Capacity is specific to a particular decision and can change.

In July 2016, in response to concerns about assessment of capacity to consent to psychiatric treatment, the Mental Health Commission issued guidance for approved centres with regard to Part 4 of the Mental Health Act – Consent to Treatment in order to increase compliance. Inter alia, it stated *Following the administration of medication for a continuous period of 3 months, the patient's responsible consultant psychiatrist must assess their patient's ability to consent to the treatment; this includes an assessment of the patient's ability to understand the nature, purpose and likely effects of the proposed treatment. There must be documented evidence that the responsible consultant psychiatrist has undertaken this assessment. This may be evidenced by a capacity assessment, or equivalent.*

It is evident that further work must be done by approved centres to ensure that they are in compliance with the law.

Physical Restraint

Physical restraint is defined as the use of physical force by one or more persons for the purpose of preventing the free movement of a service user's body when he or she poses an immediate threat of serious harm to self or others[9]. Physical restraint should be used only when less restrictive interventions have been determined to be ineffective to protect the service user, a staff member, or others from harm. Physical restraint is a traumatic experience for the service user. For a service user on a psychiatric ward, being physically restrained by staff is not only humiliating and distressing, but can also be dangerous – even life-threatening.

In 2014 the Mental Health Commission developed a strategy for reducing the use of seclusion and restraint[10].

The Mental Health Commission has issued a Code of Practice on the Use of Physical Restraint in Approved Centres and all approved centres should adhere to this Code in order that the rights of service users are respected. Of 60 approved centres that used physical restraint, 22% were compliant with the Code of Practice. The main reasons why approved centres were non-compliant were poor documentation, lack of a physical examination following physical restraint and lack of training in techniques for preventing aggression and violence.

50%

NON-COMPLIANCE WITH CONSENT PROCEDURES

OF THESE **79% FAILED** TO ASSESS CAPACITY

To demonstrate capacity, individuals should be able to

- **Understand what the medical treatment is, its purpose and nature and why it is being proposed.**
- **Understand the benefits, risks and alternatives.**
- **Understand the consequences of not receiving the proposed treatment.**
- **Retain the information and be able to weigh up the pros and cons in order to arrive at a decision.**
- **Communicate the decision.**

8 *Consent tool kit; British Medical Association*

9 *Code of Practice on the Use of Physical Restraint in Approved Centres. Mental Health Commission 2009*

10 *Seclusion and Restraint Reduction Strategy. Mental Health Commission December 2014*

> ...poor documentation, lack of a physical examination following physical restraint and lack of training in techniques for preventing aggression and violence.

22%

COMPLIANCE WITH PHYSICAL RESTRAINT

> For a service user on a psychiatric ward, being physically restrained by staff is not only humiliating and distressing, but can also be dangerous – even life-threatening."

Physical restraint is a restrictive practice and, as noted above, entails physical risks. It is of note that the Code of Practice is only a guidance for approved centres. The Mental Health Act does not allow for the making of Rules for physical restraint, with the result that there cannot be enforcement if there is non-adherence to the Code of Practice. Protection for service users during physical restraint would be increased if there was a statutory basis governing physical restraint.

The Inspector urges that, in the revision of the Mental Health Act, consideration is given to the making of Rules with regard to physical restraint.

SECTION 26 OF THE MENTAL HEALTH ACT – ABSENCE WITH LEAVE

Section 26 of the Mental Health Act provides that the consultant psychiatrist responsible for the care and treatment of a patient may grant permission in writing to that patient to be absent from the approved centre for such a period as the consultant psychiatrist may specify, but for a period less than the unexpired hospital detention order. The original intention of s26 was to allow patients to gradually re-integrate into the community on a planned basis, leading to appropriate discharge. The consultant psychiatrist, under s26(2), may, if he/she is of the opinion that it is in the best interests of the patient, withdraw the permission and direct the patient to return to the approved centre. There are procedures for enforcement of these provisions and if the patient refuses to return to approved centre, an Garda Síochána can provide assistance to remove the patient to the approved centre.

It should be noted that, after the enactment of the European Convention of Human Rights in 2003, the consultant psychiatrist's powers to withdraw leave and order the patient to return to hospital must be exercised with Article 5(1), the right to liberty and security, of the Convention[11].

11 European Convention on Human Rights. Council of Europe

Treatment is not forced on a patient on s26 leave in the community; if there is non-adherence to medication, leave can be withdrawn and the patient returned to the approved centre.

The Interim Report of the Steering Group on the review of the Mental Health Act 2001[12] highlighted concerns that, over time, this provision has allowed some patients to be absent on a continued basis from approved centres through the ongoing renewal of detention orders, thereby facilitating a kind of de facto community detention.

The report of the Expert Group Review of the Mental Health Act, 2001[13] stated that a leave of absence can be an important part of a patient's care plan and recommended that the existing powers under s26 should remain because the granting of leave to patients is appropriate in certain circumstances, but that such leave should be clearly subject to a specified time limit, a maximum of 14 days. It stated that the provisions of this section should not be used as quasi–community treatment orders. The Group also recommended that greater clarification on the precise circumstances in which such provisions can be used should be provided in a Code of Practice to be developed by the Mental Health Commission. The Expert Group did not recommend the introduction of CTOs and, in the absence of such a recommendation, it is unlikely that the Mental Health Act will be amended in the near future to include such a provision.

There is evidence that s26 leave is being used by some psychiatrists as a de facto CTO, where non-compliance with conditions results in a return to detention in approved centre. Section 26 should not be used for extended periods or as a CTO. During the 2016 inspections, the Inspector found that six patients were on section 26 leave for periods of more than 14 days. These patients were residing at home, in another facility which was not a mental health facility, or in a community residence.

CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

There has been much concern publicly and by the Mental Health Commission about the admission of young people under the age of 18 to adult approved centres. *A Vision for Change*[14], recommends that children up to the age of 18 years who require in-patient mental health services should be admitted to dedicated child and adolescent in-patient units. In the Code of Practice Relating to Admission of Children under the Mental Health Act 2001, the Mental Health Commission set out that, from December 2011, no admission of a child under the age of 18 years to adult units was to take place. If due to exceptional circumstances, an admission of a child to an adult approved centre takes place in contravention of the above, the approved centre must submit a detailed report on a specified clinical practice form to the Mental Health Commission.

68

ADMISSIONS OF CHILDREN TO ADULT UNITS IN 2016

DOWN FROM **96 IN 2015**

"The drop in admissions of children to adult approved centres from previous years is to be welcomed."

12 The Interim Report of the Steering Group on the Review of the Mental Health Act 2001 (2012)

13 Report of the Expert Group Review of the Mental Health Act, 2001

14 A Vision for Change: Report of the Expert Group on Mental Health Policy

68 CHILD ADMISSIONS TO ADULT UNITS

19 ADULT APPROVED CENTRES ADMITTED CHILDREN

46% FEMALES

54% MALES

BETWEEN **13** AND **17** YEARS OLD

DURATION OF STAY FROM LESS THAN **1** DAY TO **84** DAYS

There was a total of 68 admissions of children to adult approved centres in 2016. This represents 13% of all admissions of children (19% in 2015). The drop in admissions of children to adult approved centres from previous years is to be welcomed.

Year	2012	2013	2014	2015	2016
Number of admissions of children to adult approved centres	107	98	92	96	68

Specialist child and adolescent mental health services (CAMHS) in-patient services are registered approved centres under the Mental Health Act, 2001. They operate under the legislative framework of the Act and the regulatory codes of practice and standards of the Mental Health Commission. The overall number of HSE registered beds in CAMHS in-patient units has increased, which has resulted in the reduction in the number of children admitted to adult approved centres and in the length of stay in adult centres. The number of HSE CAMHS registered beds has increased from 64 in 2015 to 76 in 2016. However, the actual number of HSE operational beds was 66 due to the lack of staffing in Éist Linn in Cork and consequent bed reduction.

There continues to be a lack of out-of-hours provision of CAMHS service in many areas.

A weekly referrals teleconference call takes place between the four HSE in-patient CAMHS units. This forum reviews all referrals to each of the CAMHS units and identifies available beds across the country. It also highlights when a child/young person is placed in an adult approved centre and identifies a lead CAMHS unit to progress admission screening assessment in such cases.

Community Healthcare Organisation (CHO) 1, CHO 4 (Kerry only), CHO 5 and CHO 8 have no out-of-hours CAMHS service. In these areas, children with mental health needs are assessed in the emergency department by non-consultant hospital doctors and consultant psychiatrists who are not CAMHS specialists. These psychiatrists do not have access to the child's clinical file, making it more likely that the child will be admitted to an adult approved centre as out-of-hours admission to CAMHS approved centres is usually not possible. This results in an uneven provision of CAMHS emergency services with some areas not receiving any emergency CAMHS service.

The Quality Framework for Mental Health Services in Ireland (2007) states that the *mental health service should be available on a 24-hour basis, seven days a week.* It also states that *Members of the general public, primary care services, service users and families/chosen advocates, receive information about: what services are available; how they work; how to access them, especially in a crisis*[15].

The HSE launched a CAMHS Standard Operating Procedure in 2015, the purpose of which is to ensure the following:

- The delivery of services by child and CAMHS teams is carried out in a consistent and transparent manner in Ireland.
- The care and treatment offered reflects the identified clinical needs of the child.
- The children and young people who access treatment programmes for similar clinical presentations will receive a level of clinical care that is consistent across all CAMHS.
- Clear direction and information is provided for CAMHS teams and other partner services about CAMHS provision.

In the Standard Operating Procedure, it states that emergency referrals are responded to within the same working day. It does not, however, address the issue of out-of-hours presentations of children to emergency departments.

CAMHS in Ireland is under-resourced and there are ongoing difficulties filling approved CAMHS posts. Many of the recommendations of *A Vision for Change* for eating disorders, forensic services, substance misuse and mental health intellectual disability teams for young people are not yet implemented.

This would undoubtedly lead to a further reduction in admissions of children to adult approved centres and to the provision of better care and treatment for young people with mental health difficulties.

Clear accessible pathways to out-of-hours emergency services and beds are required. It must be a priority of the HSE to provide emergency CAMHS services in all CHO areas.

COMMUNITY RESIDENCES

Since the commencement of the closure of large psychiatric institutions, residences that are staffed 24 hours a day have opened in the community. Initially facilitating service users who had been long stay in psychiatric hospitals, 24-hour supervised residences now also accommodate people who have been discharged from both long-stay and acute mental health care services. There are 122 24-hour supervised residences accommodating 1,355 service users. There is an uneven spread of these residences across CHO areas.

In 2006, *A Vision for Change*[16] recommended that 24-hour supervised residences should have a maximum of ten places to foster a non-institutional environment. In 2016, 46% of residences had more than 10 beds and 49% of those had 15 or more beds. The HSE's report on accommodation for people with disabilities, *Time to Move on from Congregated Settings*, recommends that the home-sharing arrangement should be confined to no more than a total of four service users[17]. Large residences are institutions, are stigmatising and do not meet service users' needs for community living.

15 A Vision for Change. Report of the Expert Group on Mental Health Policy 2006

16 A Vision for Change. Report of the Expert Group on Mental Health Policy 2006

17 Time to Move on from Congregated Settings: A Strategy for Community Inclusion: Report of the Working Group on Congregated Settings. Health Service Executive June 2011

122 24-HOUR SUPERVISED RESIDENCES

1,355 SERVICE USERS

46% OF RESIDENCES HAD **10+** BEDS. OF THOSE, **49%** HAD **15+** BEDS

> **Large residences are institutions, are stigmatising and do not meet service users' needs for community living."**

Number of 24-hour supervised community residences per CHO

CHO	Number of residences	Number of beds	Number of beds per 100,000 population**
CHO 1	9	130	32
CHO2	17	133	29
CHO 3	9	116	30
CHO 4	14	191	35
CHO 5	23	261	51
CHO 6	4	62	14
CHO 7	6	73	11
CHO 8	14	145	23
CHO 9	10	128	21
CHO 9 MHID*	14	101	17
National Forensic Service	2	16	0.33

**Mental Health and Intellectual Disability*

*** 2016 population figures provided by the CHOs*

Of concern is that these 24-hour supervised residences are not regulated. Although the Mental Health Act permits the Inspector to visit and inspect "any other premises where mental health services are being provided", community residences are not subject to regulation by the Mental Health Commission. There are risks attached to unregulated residences for vulnerable people. Residences for people with intellectual disability are regulated by Health Information and Quality Authority (HIQA)[18,19]. It is difficult to understand why the same standard does not apply to residences for people with mental illness. The report of the Expert Group on Review of the Mental Health Act recommends that *The new Act should give the Mental Health Commission specific powers to make standards in respect of all mental health services and to inspect against those standards. The Standards should be made by way of regulations and the regulations should be underpinned by way of primary legislation.*

FORENSIC SERVICES

There is a National Forensic Mental Health Service (NFMHS), which consists of in-patient services, out-patient services, a day centre, prison in-reach, court liaison service, community residences and independent living. The Central Mental Hospital (CMH) is the NFMHS' in-patient service. It is located in Dundrum, Dublin, and is registered for 93 patients. Patients are admitted under the Mental Health Act 2001 and the Criminal Law (Insanity) Act 2006. The CMH provides high and medium levels of therapeutic security and includes rehabilitation and recovery as well as a unit for those with an intellectual disability.

In the meantime, an existing ward in the hospital has been renovated to provide ten extra beds. It has not, however, been possible to open this ward due to staffing shortages. There is a lack of parity of care for female patients of the NFMHS, who are all cared for in one unit, regardless of risk or rehabilitation status. Retention and recruitment of staff is a major challenge for the service.

At present in Ireland, there are only two forensic mental health in-patient beds per 100,000 population. In England and Wales, there are 7.5 secure forensic beds per 100,000 for the mentally ill. Scotland, Northern Ireland and Germany provide between eight and ten forensic secure beds per 100,000 population.

The Central Mental Hospital building is over 150 years old and is not suitable for the care and treatment of patients suffering from mental illness. Approval has been received for the development of a new 140-bed hospital in Portrane in north Dublin and building works have commenced, with an expected completion date of 2019.

The majority of young people remanded to Irish prisons with diagnoses of severe and enduring mental illnesses are charged with very minor offences. These patients have fallen through the cracks of a public mental health system which is not designed to meet their needs.

There was a low admission rate in 2016 as there were few short-term admissions and no turnover of beds due to the increasing numbers of Not Guilty by Reason of Insanity (Criminal Law (Insanity) Act 2006) patients. This has resulted in 19 prisoners retained in prison while on the waiting list for psychiatric care (as of 14 December 2016). There is a risk that these prisoners will be released before they access appropriate treatment.

People with a mental illness are over-represented in the prison population. Internationally, the pooled prevalence of psychosis in prisoners is 3.6% for males and 3.8% for females[20]. Prison populations are usually difficult to engage with and are vulnerable in many ways, including poverty, substance abuse, break-up of family relationships, lack of education and homelessness. They may also lack access to early intervention for their mental illness, ongoing treatment for mental illness and provision of in-patient mental health care.

18 The Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities)

19 The Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults)

20 Fazel S., Seewald K. Severe mental Illness in 33,588 prisoners worldwide: Systemic review and meta regression analysis. British Journal of Psychiatry Vol 200:5 2012

Prisoners with mental illness should have the same level of mental health care as the rest of the population. As outlined, there are a number of serious concerns about the provision of mental health services to mentally ill prisoners and there is an inadequate number of forensic beds for those prisoners who require in-patient psychiatric treatment.

As well as providing forensic in-patient care in the CMH, forensic mental health services assess and treat people with a mental illness who have come into contact with an Garda Siochána, the courts and the Prison Service, as well as providing a consultation service to other mental health services for mentally ill people who have exhibited violent and challenging behaviour.

There are currently five prisons in the Dublin area, including Dóchas, the women's prison. There are also prisons in Limerick, Cork, Portlaoise and Castlerea.

The Prison In-reach and Court Liaison Service includes the provision of mental health services to nine prisons and two court liaison services in Clover Hill and the Midlands Prison. The NFMHS also provides a service to Oberstown Children Detention Campus in conjunction with the Irish Youth Justice Service and is developing a forensic Child and Adolescent Mental Health Service. There is a prison in-reach service in Cork prison and a limited service in Limerick prison. A prison in-reach service for Castlerea is being initiated. All mental health services to the prisons are funded by the HSE.

There is a high support unit (HSU) in Mountjoy Prison, which has nine cells and one seclusion cell. This unit, while not a substitute for hospital transfer, provides improved observation in a structured physical environment. The remainder of the prisons in Dublin and Portlaoise have clinical sessions provided by consultant psychiatrists and community nurses. No other prison has a HSU.

A further ten beds will be provided in the CMH in 2017, which is to be welcomed in that it will allow an increased number of mentally ill prisoners to receive appropriate treatment. Recruiting staff for this unit has been a problem, and the condition of the building is poor and not suitable to provide an in-patient service. However, the new forensic mental health hospital in Portrane will not be completed for a number of years.

COMMUNITY HEALTHCARE ORGANISATION MENTAL HEALTH SERVICES

In 2016, the Inspector met with the Area Management Teams of each Community Healthcare Organisation (CHO) and with the Senior Management Teams of the independent hospitals. There are nine CHOs and five independent hospitals. The aim of these meetings was to obtain an overview of each CHO and the services offered by the independent hospitals. A particular emphasis was placed by the Inspector on obtaining information about service user involvement and initiatives in mental health services. Information was also obtained about funding, the number of mental health teams, in-patient facilities, child and adolescent services and the challenges faced by the services.

It is of note that not all CHOs were fully integrated and some operated with standalone mental health areas within the CHO. This is transitional. Given the present governance structure, it is expected to have all CHOs fully integrated in the near future.

The reports for the individual CHOs and independent hospitals are located in a separate report entitled *Overview of National Mental Health Services*, which is available on the Commission's website at www.mhcirl.ie

Service User Involvement and Initiatives

It was heartening to see programmes that encourage service user involvement and recovery being rolled out nationally. Some of these are described below. Many CHOs and independent hospitals ran a wide variety of individual programmes and projects for service users and details of these can be found in the report of *Overview of National Mental Health Services.*

The HSE Mental Health Division is engaged in enhancing service user, family member and carer engagement through continued development of the HSE Office of Service User Engagement. It is in the process of appointing a Head of Service User Engagement to each CHO mental health management team.

In most mental health services, there is an enthusiasm for providing accessible information for service users and carers about services, mental illness and recovery. Many services have signed up to EOLAS programmes. These are mental health information and learning programmes with a focus on assisting participants' recovery journeys. There are two programmes: One is designed for persons diagnosed with schizophrenia spectrum or bipolar disorder and the other is for their families and close friends. The information is provided by service users, family members and clinicians working together using knowledge gained by lived experience and clinical expertise.

ARI Recovery Committee work

- Recovery Principles Training: Sharing experiences of mental health distress in training mental health professionals.
- Developing Recovery Colleges: Places that provide recovery orientated educational courses and workshops for people with mental health difficulties and their supporters.
- Peer-led Involvement Centres: Developing centres that support people with mental distress, run by people who have themselves have had similar experiences.
- Consumer Panel: Meetings to share views on the local mental health service and to feed this back to the service.
- Recovery Story-telling: Supporting people in hospital by sharing recovery stories.
- Trialogues: A monthly forum held in a community space where those interested in mental health come together to discuss issues, share hope, gain insight and listen to each other.

> It was heartening to see programmes that encourage service user involvement and recovery being rolled out nationally."

CHOs have become part of Advancing Recovery in Ireland (ARI), which brings together people who provide mental health services, those who use them and their families, and community supports, to improve mental health services by bringing recovery principles into mental health care provision. This is in line with the mental health national policy, *A Vision for Change*. ARI supports the development of local groups (Recovery Committees) in advancing recovery practices. These groups consist of service users, family members and service providers working together[21].

ARI is well developed in many CHOs and is in progress in others. This is an excellent initiative that involves service users in their own recovery.

Peer Support Workers

With the advent of the recovery movement, interest in peer support has grown in many mental health systems. Peer support can help people become more engaged and empowered. In Ireland, peer support workers are being employed by the HSE in all CHOs and this will continue into 2017. Peer support workers have attended a specific course for peer support workers in Dublin City University.

In 2016, the most cited challenge was the difficulty in recruiting staff.

Challenges for CHOs

CHOs and independent hospitals face a number of challenges in providing mental health services.

In 2016, the most cited challenge was the difficulty in recruiting staff. This challenge was evident across all disciplines but was most acute in relation to nursing and medical staff. There was particular difficulty in recruiting consultant psychiatrists in Child and Adolescent Psychiatry. There were also staff-retention issues. Many areas had large number of nurses who had retired or were due to retire, adding to the burden of finding appropriate staff. Vacancies were filled by agency staff and overtime. There was also a lack of replacement for maternity leave, which left health and social care professional posts vacant for up to a year.

The area of rehabilitation was a difficulty for some CHOs. There was inadequate provision of rehabilitation teams, both in number and in staffing. There was a lack of community accommodation for service users who needed to move from in-patient care, but also for those

21 *https://www.hse.ie/eng/services/list/4/Mental_Health_Services/advancingrecoveryireland/*

people currently in supervised residences to move to more independent living. Some CHOs were aware that the number of service users in 24-hour supervised residences was too high but did not have funding to provide smaller community residences. This service user group represents a cohort of people who are stuck in a system that is not providing appropriate care based on need and, in some cases, no rehabilitation.

The independent hospitals also had difficulties with recruitment, especially in relation to nursing staff. Another challenge was that private health insurers currently provide limited cover for non-residential treatments, which are mostly funded by the service user. This acts as a barrier to the development of community services. It can also have the effect of increasing admissions to in-patient care, increasing the length of time a service user remains in hospital unnecessarily and prolonging the duration of untreated illness where service users defer decisions to seek treatment until a crisis arises.

CARERS AND FAMILIES

The Inspector welcomed the opportunity to meet with the families and carers of patients in the Central Mental Hospital (CMH) and of service users in St Joseph's Intellectual Disability Services.

They highlighted the fast turnover of staff in the CMH, especially in the occupational therapy department. There was concern about the slow progress in building the new forensic facility

The Inspector welcomed the opportunity to meet with the families and carers of patients in the Central Mental Hospital (CMH) and of service users in St. Joseph's Intellectual Disability Services.

in Portrane and the continued detention of their relatives in a building that was not fit for purpose. The group expressed concern at the lack of facilities for discharged patients and at the resistance of local mental health services to facilitate the discharge of patients to their local areas.

The Inspector also met with the families and carers of service users in St. Joseph's Intellectual Disability Services. Lack of staffing had caused difficulties for their relatives, especially when they are transferred from St. Joseph's to Beaumont Hospital for general medical care. As this group of service users is particularly vulnerable, it seems essential that a familiar nurse or health care assistant (HCA) would accompany them. Unfortunately, this is not the case due to staffing shortages. It also puts an extra burden on service users' families to remain with them during their hospital stay. A liaison nurse has been appointed to facilitate transfers and this has gone some way to ease the difficulties. While it would be good practice to have a nurse or HCA familiar with the service user accompany him or her, it is hard to see how this can be achieved in light of current staffing constraints.

CONCLUSION

It is evident that most services are working hard to be compliant with Regulations, Rules and Codes of Practice for approved centres. The Inspector found areas of compliance with excellent quality ratings. There was evidence of approved centres completing audits of processes which have gone on to improve compliance and quality. Staffing shortages hampered progress in some areas.

It is encouraging to see programmes that increase service user involvement and recovery being rolled out nationally. Advancing Recovery in Ireland is an excellent HSE national initiative, which is aimed at bringing about the organisational and cultural changes necessary to support mental health services in becoming more recovery-oriented. The HSE has appointed a Head of Service User, Family Member and Carer Engagement to the HSE National Mental Health Management Team. Following this, nine area leads for Mental Health Engagement have been appointed as members of the mental health services area management teams.

It is important that service user involvement is also respected in approved centres. While the acuity of illness may make it difficult for service users to initially engage with staff in approved centres, every effort must be made to include service users in their care and treatment. Most staff in approved centres are able to articulate a recovery model of care, but this is not always evident on the ground. In many centres, service users have no input into their individual care plans and, when asked by inspectors, have no awareness that they even had a care plan, let alone a copy of it. Service users having a say in their care and treatment is the basis of recovery-orientated care. The assessment, planning, and delivery of care, treatment and support should be centred on service users as individuals and consider all aspects of their individual circumstances and their immediate and longer-term needs. Individual care plans must be developed with service users and, where appropriate, those acting on their behalf. Individual care plans should reflect service user needs, preferences and diversity.

An attitudinal change is required within the mental health services about individual care planning. This depends on leadership, training, and engagement by the multi-disciplinary team as well as actively involving the service user in his or her care plan. Service users should be made aware that they have a right to a multi-disciplinary individual care plan and a right to be involved in its development and review. The HSE is urged to address the issue of meaningful care planning as a matter of urgency.

Allied to the recovery model is respect for privacy and dignity. It is disturbing to see the extent of non-compliance with the Regulation on privacy. Time after time, inspectors encountered examples of torn or absent privacy curtains around beds, broken locks on toilet doors, and no facilities to make a private phone call, all of which adds to a sense of loss of control for service users. Lack of respect for dignity was also demonstrated in the state of accommodation offered to service users in some approved centres. Some were dirty and lacked basic cleaning and maintenance. Newer approved centres were impressive in their design, especially with regard to single bedrooms and communal and therapeutic space.

Ligature points remain a concern and one that is shared by the approved centres. There is evidence of substantial remediation work in many approved centres. It is challenging to make premises completely risk-free, but regular ligature audits and risk assessments have identified areas for improvement and in most cases these are being addressed.

There are concerns over the use of seclusion in approved centres. Seclusion is a restrictive and coercive practice. Evidence found during the 2016 inspection raises questions about reasons for secluding a service user, lengthy periods of time that a service user is in seclusion, the ability of some but not all approved centres to treat service users without recourse to seclusion, the use of seclusion as punishment, and efforts to reduce the use of seclusion and restraint. There needs to be an increased awareness of the ethical and human rights issues involved in seclusion and increased engagement in actively reducing the frequency and length of seclusion.

There are 122 24-hour supervised residences accommodating 1,355 residents nationally. This represents a large cohort of vulnerable people with long-term mental illness. Many had resided in large psychiatric institutions for many years; others, because of mental health difficulties, require a level of support in their everyday lives. There are risks to vulnerable people living in such circumstances in terms of abuse, not receiving adequate mental health care and physical care, living in inadequate accommodation and losing autonomy. At present, while the Inspector may visit, these 24-hour supervised residences are not regulated. It is essential that these residences are regulated as a matter of urgency, and the Inspector urges that revision of the Mental Health Act includes provision for regulation for community residences.

Dr Susan Finnerty MCRN: 009711
Inspector of Mental Health Services

Appendix 1

Approved centres by region and bed number

Table 1: Approved Centre, Area / Sector, Geographical Location and Bed Numbers

Area / Sector	Geographical Location	Bed Number*	Approved Centre [name as registered]
CHO Area 1	Donegal, Sligo/Leitrim/West Cavan, Cavan Monaghan	25	Acute Psychiatric Unit, Cavan General Hospital
		34	Department of Psychiatry, Letterkenny General Hospital
		20	Rehab and Recovery Mental Health Unit, St John's Hospital Campus
		34	Sligo/Leitrim Mental Health In-patient Unit
		20	St Davnet's Hospital - Blackwater House
CHO Area 2	Galway, Roscommon, Mayo	32	Adult Mental Health Unit, Mayo University Hospital
		22	An Coillín
		16	Creagh Suite, St Brigid's Healthcare Campus
		22	Department of Psychiatry, Roscommon University Hospital
		45	Department of Psychiatry, University Hospital Galway
		12	St Anne's Unit, Sacred Heart Hospital
		10	Teach Aisling
		21	Wood View
CHO Area 3	Clare, Limerick, North Tipperary/East Limerick	50	Acute Psychiatric Unit 5B, University Hospital Limerick
		39	Acute Psychiatric Unit, Ennis Hospital
		34	Cappahard Lodge
		21	Tearmann Ward, St Camillus' Hospital
CHO Area 4	Kerry, North Cork, North Lee, South Lee, West Cork	50	Acute Mental Health Unit, Cork University Hospital
		18	Carraig Mór Centre
		18	Centre for Mental Health Care and Recovery, Bantry General Hospital
		32	O'Connor Unit, St Finan's Hospital
		29	Owenacurra Centre
		39	Sliabh Mis Mental Health Admission Unit, University Hospital Kerry
		21	St Catherine's Ward, St Finbarr's Hospital
		50	St Michael's Unit, Mercy University Hospital
		93	Units 2, 3, 4, 5, and Unit 8 (Floor 2), St Stephen's Hospital
CHO Area 5	South Tipperary, Carlow Kilkenny, Waterford, Wexford	44	Department of Psychiatry, St Luke's Hospital
		44	Department of Psychiatry, University Hospital Waterford
		40	Grangemore Ward & St Aidan's Ward, St Otteran's Hospital
		40	Haywood Lodge
		20	Selskar House, Farnogue Residential Healthcare Unit
		20	St Gabriel's Ward, St Canice's Hospital

Area / Sector	Geographical Location	Bed Number*	Approved Centre [name as registered]
CHO Area 6	Wicklow, Dun Laoghaire, Dublin South East	55	Avonmore and Glencree Units, Newcastle Hospital
		39	Elm Mount Unit, St Vincent's University Hospital
		52	Le Brun House & Whitethorn House, Vergemount Mental Health Facility
CHO Area 7	Kildare/West Wicklow, Dublin West, Dublin South City, Dublin South West	52	Acute Psychiatric Unit, Tallaght Hospital
		51	Jonathan Swift Clinic
		29	Lakeview Unit, Naas General Hospital
CHO Area 8	Laois/Offaly, Longford/West Meath, Louth/ Meath	44	Admission Unit and St Edna's Unit, St Loman's Hospital
		46	Department of Psychiatry, Midland Regional Hospital, Portlaoise
		46	Drogheda Department of Psychiatry
		30	Maryborough Centre, St Fintan's Hospital
		42	St Bridget's Ward & St Marie Goretti's Ward, Cluain Lir Care Centre
		20	St Ita's Ward, St Brigid's Hospital
CHO Area 9	Dublin North, Dublin North Central, Dublin North West	44	Ashlin Centre
		47	Department of Psychiatry, Connolly Hospital
		25	O'Casey Rooms, Fairview Community Unit
		54	Phoenix Care Centre
		15	St Aloysius Ward, Mater Misericordiae University Hospital
		46	St Vincent's Hospital
		25	Sycamore Unit, Connolly Hospital
Independent Service Provider	All located in Dublin	114	Bloomfield Hospital
		110	Highfield Hospital
		7	Lois Bridges
		52	St Edmundsbury Hospital
		183	St John of God Hospital
		241	St Patrick's University Hospital
CAMHS	Dublin, Galway and Cork	12	Adolescent In-patient Unit, St Vincent's Hospital, Dublin
		20	Child and Adolescent Mental Health In-patient Unit, Merlin Park University Hospital, Galway
		20	Eist Linn Child and Adolescent In-patient Unit, Cork
		24	Linn Dara Child and Adolescent Mental Health In-patient Unit, Cherry Orchard, Dublin
		14	Willow Grove Adolescent Unit, St Patrick's University Hospital, Dublin
National Specialist Services	All located in Dublin	93	Central Mental Hospital – National Forensic Mental Health Service
		124	St Joseph's Intellectual Disability Service

Note: *Bed numbers: registered beds as at 31 December 2016. CHO = Community Health Organisation, Health Service Executive. CAMHS = Child and Adolescent Mental Health Service.

Appendix 2

Safeguarding service user rights: Mental Health Tribunals

Figure 1:
Monthly Involuntary Admissions 2016

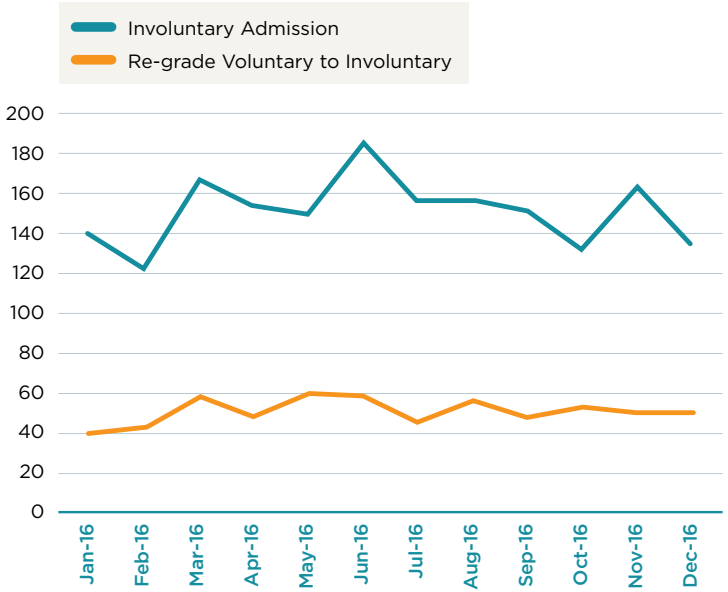
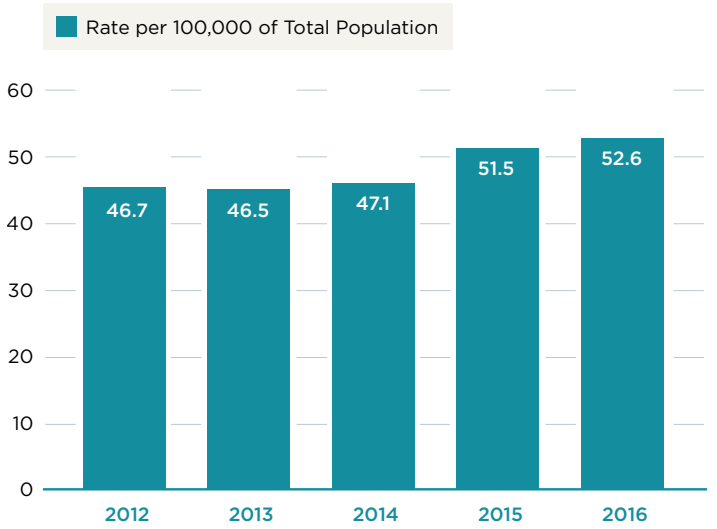


Figure 2:
Involuntary Admission Rates per 100,000 of total population* 2012 to 2016



*Population figures taken from CSO census 2011

Table 1:
Involuntary Admission Rates for 2016 (Adult) by CHO Area and Independent Sector

	Involuntary Admissions	Re-grade Voluntary to Involuntary	Total involuntary admissions	Population	Involuntary Admission Rate per 100,000 total population
CHO1	152	50	202	389,048	51.9
CHO2	187	47	234	445,356	52.5
CHO3	128	45	173	379,327	45.6
CHO4	244	103	347	664,534	52.2
CHO5	168	47	215	497,578	43.2
CHO6	126	18	144	364,464	39.5
CHO7	218	59	277	674,071	41.1
CHO8	188	47	235	592,388	39.7
CHO9	246	102	348	581,486	59.8
Independent Sector	151	88	239	N/A	N/A
TOTAL (Exclusive of Independent sector)	**1,657**	**518**	**2,175**	**4,588,252**	**47.4**
TOTAL (Inclusive of Independent sector)	**1,808**	**606**	**2,414**	**4,588,252**	**52.6**

Note: *Detailed analysis of involuntary admission rates for 2016 by Approved Centre is provided on the Mental Health Commission website www.mhcirl.ie

Table 2:
Analysis by Age - Involuntary Admissions 2016 (adults)

Age	Form 6	Form 6 Female	Form 6 Male	Form 13	Form 13 Female	Form 13 Male	Total	%
18 – 24	212	46	166	88	32	56	300	12%
25 - 34	378	134	244	145	77	68	523	22%
35 - 44	381	160	221	144	79	65	525	22%
45 - 54	326	172	154	96	49	47	422	17%
55 - 64	217	113	104	76	48	28	293	12%
65 and over	294	147	147	57	34	23	351	15%
Total	**1,808**	**772**	**1036**	**606**	**319**	**287**	**2,414**	**100%**

Table 3:
Analysis by Gender
- Involuntary Admissions 2016 (adults)

Gender	Form 6	Form 13	Total	%
Female	772	319	1091	45%
Male	1036	287	1323	55%
Total	**1808**	**606**	**2414**	**100%**

Table 4:
Analysis by applicant type
- Involuntary Admissions 2016 (adults)

Form	Type	Total	%
1	Spouse, Civil Partner, Relative	786	44%
2	Authorised Officer (Health Service Executive)	242	13%
3	Garda Síochána	455	25%
4	Any Other Person	325	18%
Total		**1808**	**100%**

Figure 3:
Number of orders revoked before hearing by Responsible Consultant Psychiatrists under the provisions of the Act 2012 - 2016

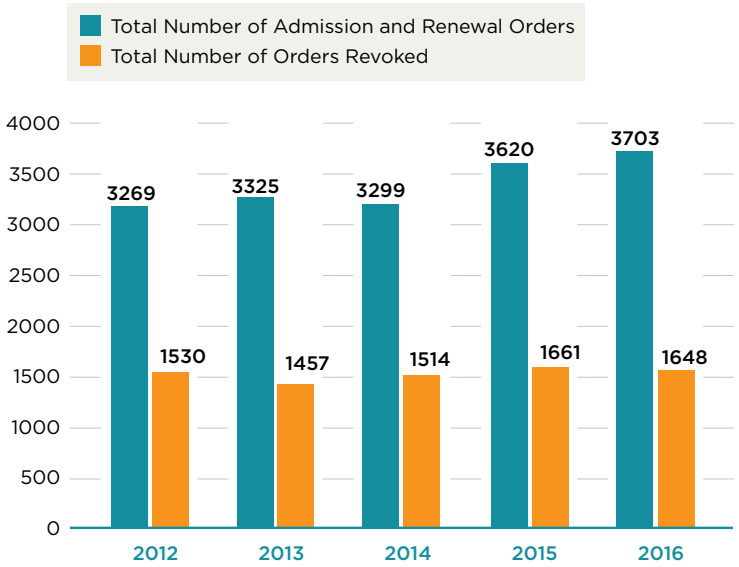


Figure 4:
Number hearings and % of orders revoked at hearing 2016

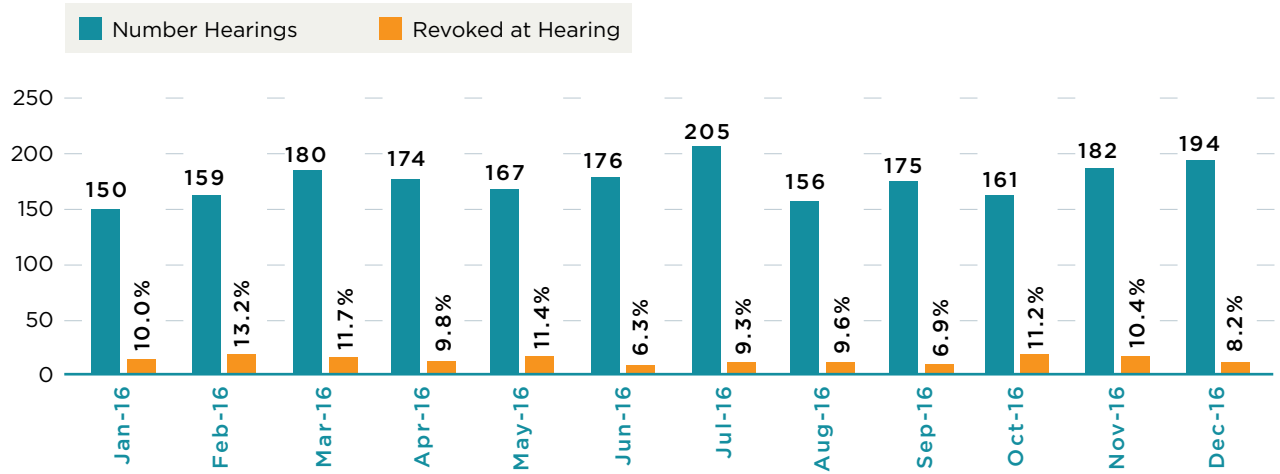
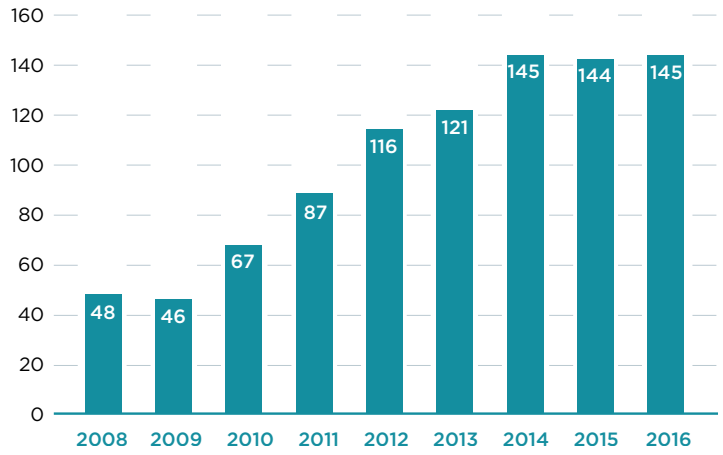


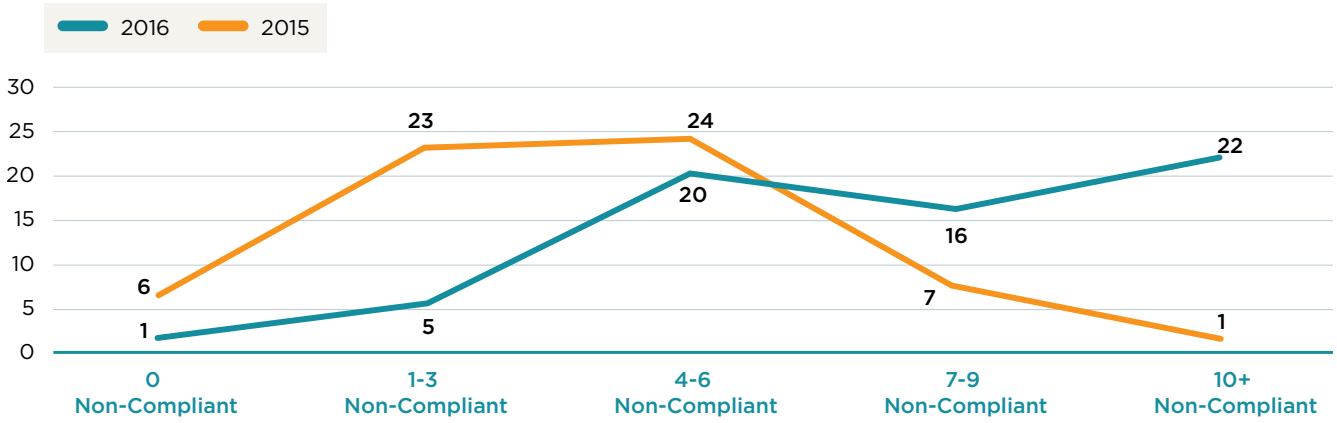
Figure 5:
Number of Circuit Court Appeals 2008 - 2016



Appendix 3

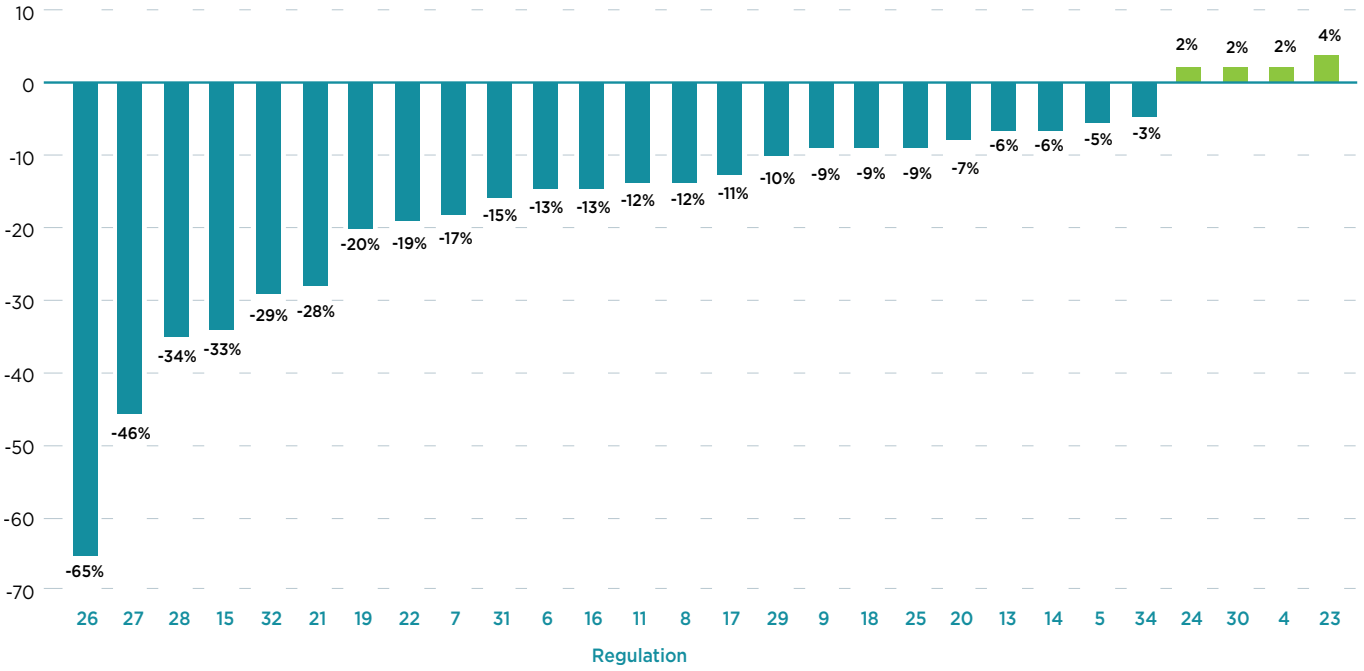
Encouraging continuous quality improvement: Compliance

Figure 1: Number of Non-Compliant Regulations per Approved Centre 2015 – 2016



Note: 2016: total number of non-compliant regulations ranged from 0 – 15 per approved centre [N = 64], average number of non-compliant regulations per approved centre n = 7.8; 2015: total number of non-compliant regulations ranged from 0 – 11 per approved centre [N = 61], average number of non-compliant regulations per approved centre n = 3.7.

Figure 2: Percentage Difference in Compliance Per Regulation 2015 – 2016



Regulation Key

23	Medication (+4%)	8	Residents' Property
4	Identification	11	Visits
30	Tribunals	16	Therapeutic Services
24	Health and Safety	6	Food Safety
34	Certificate	31	Complaints
5	Food and Nutrition	7	Clothing
14	Care of the Dying	22	Premises
13	Searches	19	General Health
20	Information	21	Privacy
25	CCTV	32	Risk Management
18	Transfers	15	Individual Care Plans
9	Recreational Activities	28	Register of Residents
29	Policies	27	Records
17	Children's Education	26	Staffing (-65%)

Note: No change in % compliance from 2015-2016 for Regulation 10 [Religion], 12 [Communication] and 33 [Insurance].

Tables: 1-12: Number of Non-Compliant Regulations per Approved Centre 2015 – 2016

Note: The average number of non-compliant regulations per approved centre in 2016 was n = 7.8 and in 2015 was n = 3.7. DOP = Department of Psychiatry. CHO = Community Health Orgainisation. CAMHS = Child and Adolescent Mental Health Service.

1. CHO 1	2016	2015	Difference
DOP Letterkenny	5	5	No change
St Davent's Hospital	10	6	-4
APU Cavan	10	4	-6
Sligo Leitrim	12	1	-11
St. John's Campus	9	-	New

2. CHO 2	2016	2015	Difference
St Anne's Sacred Heart	2	2	No change
DOP Roscommon	8	6	-2
An Coillín	4	1	-3
AMHU Mayo	6	2	-4
DOP Galway	10	4	-6
Teach Aisling	10	1	-9
Creagh Suite	5	-	New
Wood View	10	-	New

3. CHO 3	2016	2015	Difference
Cappahard Lodge	6	5	-1
APU Ennis	11	5	-6
Tearmann Ward	11	5	-6
Unit 5B Limerick	14	2	-12

4. CHO 4	2016	2015	Difference
AMHU Cork	7	7	No change
St Michael's Unit	7	7	No change
Carraig Mor Centre	6	4	-2
Sliabh Mis	9	6	-3
Bantry General	6	1	-5
St Stephen's Hospital	13	5	-8
O'Connor Unit	15	5	-10
St Catherine's Ward	15	4	-11
Owenacurra Centre	11	-	New

5. CHO 5	2016	2015	Difference
Selskar House	2	8	+6
DOP St Luke's	8	7	-1
St Otteran's Hospital	8	5	-3
Haywood Lodge	8	3	-5
DOP Waterford	13	7	-6
St Gabriel's Ward	11	4	-7

6. CHO 6	2016	2015	Difference
Vergemount	11	11	No change
Elm Mount Unit	7	5	-2
Newcastle Hospital	10	1	-9

7. CHO 7	2016	2015	Difference
Lakeview	8	6	-2
Jonathan Swift Clinic	8	2	-6
APU Tallaght	12	4	-8

8. CHO 8	2016	2015	Difference
DOP Portlaoise	5	8	+3
St Loman's Hospital	7	8	+1
Maryborough Centre	5	5	No change
Cluain Lir Care Centre	4	4	No change
St Brigid's Hospital	10	3	-7
Drogheda DOP	4	-	New

9. CHO 9	2016	2015	Difference
O'Casey Rooms	7	5	-2
Sycamore Unit	5	3	-2
DOP Connolly Hospital	6	3	-3
Phoenix Care Centre	6	3	-3
Ashlin Centre	7	3	-4
St Aloysius Ward	14	5	-9
St Vincent's Hospital	11	2	-9

10. CAMHS	2016	2015	Difference
Eist Linn	3	1	-2
AIPU St Vincent's	4	2	-2
Willow Grove	2	0	-2
Linn Dara	6	3	-3
Merlin Park	9	1	-8

11. Independent	2016	2015	Difference
St Edmundsbury	0	0	No Change
Bloomfield	5	4	-1
St John of Gods	4	2	-2
St Patrick's Hospital	3	0	-3
Lois Bridges	5	0	-5
Highfield	9	0	-9

12. National Service	2016	2015	Difference
Central Mental Hospital	6	6	No Change
St Joseph's ID	13	2	-11

IMPORTANT NOTE REGARDING USE OF DATA:

Tables 1-35 present compliance data by approved centre and Area / Sector type. The data presented in these tables does not control for all variables which may influence compliance ratings (for example, service type, size or geographical location); therefore, comparision between approved centres or Area / Sector types should be undertaken with caution. Further information on compliance can be found in the Inspector's 2015 and 2016 inspection reports on www.mhcirl.ie.

Tables: 13-23: High and low percentage compliance with regulations by Area / Sector

Note: +x denotes that there are X number more regulations at that percentage and that a sample have been selected for presentation in the table. 100% compliance for all approved centres with regulations 10 [religion], 12 [communication], and 33 [insurance]. CHO = Community Health Orgainisation. CAMHS = Child and Adolescent Mental Health Service.

13. CHO 1 (n = 5)

TOP 5			BOTTOM 5		
4	Identification	100%	26	Staffing	0%
5	Food and Nutrition	100%	15	ICP	0%
6	Food Safety	100%	22	Premises	20%
20	Information	100%	23	Medication	20%
24	Health and Safety +6	100%	32	Risk Management	20%

14. CHO 2 (n = 8)

TOP 5			BOTTOM 5		
4	Identification	100%	26	Staffing	0%
13	Searches	100%	15	Privacy	25%
19	General Health	100%	22	Premises	25%
24	Health and Safety	100%	23	ICP	50%
30	Tribunals +5	100%	32	Therapeutic Services	50%

15. CHO 3 (n = 4)

TOP 5			BOTTOM 5		
4	Identification	100%	26	Staffing	0%
5	Food and Nutrition	100%	27	Records	0%
9	Recreational Activity	100%	32	Risk Management	0%
16	Therapeutic Services	100%	21	Privacy	25%
20	Information +7	100%	22	Premises +4	25%

16. CHO 4 (n = 9)

TOP 5			BOTTOM 5*		
6	Food Safety	100%	26	Staffing	0%
10	Religion	100%	21	Privacy	11%
12	Communication	100%	22	Premises	11%
25	CCTV	100%	27	Records	11%
30	Tribunals +3	100%	15	ICP	23%

* excluding regulation 17 children's education

17. CHO 5 (n = 6)

TOP 5			BOTTOM 5		
4	Identification	100%	26	Staffing	0%
13	Searches	100%	27	Records	0%
18	Transfers	100%	15	ICP	33%
20	Information	100%	23	Medication	33%
24	Health and Safety +5	100%	28	Register	33%

18. CHO 6 (n = 3)

TOP 5			BOTTOM 5		
4	Identification	100%	26	Staffing	0%
5	Food and Nutrition	100%	15	ICP	0%
9	Recreational Activity	100%	21	Privacy	0%
16	Therapeutic Services	100%	31	Complaints	0%
24	Health and Safety +12	100%	32	Risk Management	0%

19. CHO 7 (n = 3)

TOP 5			BOTTOM 5		
4	Identification	100%	26	Staffing	0%
5	Food and Nutrition	100%	15	ICP	0%
8	Residents' Property	100%	19	General Health	0%
16	Therapeutic Services	100%	27	Records	0%
13	Searches +7	100%	32	Risk Management +1	34%

20. CHO 8 n = 6

TOP 5			BOTTOM 5		
4	Identification	100%	15	ICP	50%
5	Food and Nutrition	100%	21	Privacy	50%
6	Food Safety	100%	22	Premises	50%
9	Recreational Activity	100%	32	Risk Management	50%
24	Health and Safety +10	100%	16	Therapeutic Services +6	67%

21. CHO 9 (n = 7)

TOP 5			BOTTOM 5		
4	Identification	100%	26	Staffing	14%
5	Food and Nutrition	100%	22	Premises	29%
10	Religion	100%	27	Records	29%
12	Communication	100%	15	ICP	43%
24	Health and Safety +4	100%	23	Medication +1	43%

22. Independent (n = 6)

TOP 5			BOTTOM 5		
4	Identification	100%	26	Staffing	34%
9	Recreational Activity	100%	23	Medication	34%
16	Therapeutic Services	100%	15	ICP	50%
18	Transfers	100%	27	Records	50%
24	Health and Safety +14	100%	28	Register	50%

23. CAMHS (n = 5)

TOP 5			BOTTOM 5		
4	Identification	100%	26	Staffing	20%
9	Recreational Activity	100%	23	Medication	40%
16	Therapeutic Services	100%	21	Privacy	60%
19	General Health	100%	22	Premises	60%
24	Health and Safety +11	100%	27	Records +2	60%

Tables 24-35: Number and percentage of risk ratings of regulations by Area / Sector

24. Total (N = 64)*		
Risk	n	%
Low	104	21%
Moderate	244	49%
High	138	28%
Critical	12	2%

*including national specialist services (n = 2)

Note: Total non-compliant regulations N = 498 of 1879 applicable

27. CHO 3 (N = 4)		
Risk	n	%
Low	13	31%
Moderate	15	36%
High	11	26%
Critical	3	7%

Note: Total non-compliant regulations N = 42 of 116 applicable

30. CHO 6 (N = 3)		
Risk	n	%
Low	8	29%
Moderate	15	53%
High	5	18%
Critical	0	0%

Note: Total non-compliant regulations N = 28 of 88 applicable

33. CHO 9 (N = 7)		
Risk	n	%
Low	14	25%
Moderate	29	52%
High	10	18%
Critical	3	5%

Note: Total non-compliant regulations N = 56 of 207 applicable

25. CHO 1 (N = 5)		
Risk	n	%
Low	11	24%
Moderate	21	46%
High	13	28%
Critical	1	2%

Note: Total non-compliant regulations N = 46 of 146 applicable

28. CHO 4 (N = 9)		
Risk	n	%
Low	12	14%
Moderate	41	46%
High	35	39%
Critical	1	1%

Note: Total non-compliant regulations N = 89 of 264 applicable

31. CHO 7 (N = 3)		
Risk	n	%
Low	7	25%
Moderate	16	57%
High	5	18%
Critical	0	0%

Note: Total non-compliant regulations N = 28 of 89 applicable

34. CAMHS (N = 5)		
Risk	n	%
Low	7	29%
Moderate	16	67%
High	1	4%
Critical	0	0%

Note: Total non-compliant regulations N = 24 of 149 applicable

26. CHO 2 (N = 8)		
Risk	n	%
Low	10	18%
Moderate	25	45%
High	19	35%
Critical	1	2%

Note: Total non-compliant regulations N = 55 of 232 applicable

29. CHO 5 (N = 6)		
Risk	n	%
Low	3	6%
Moderate	29	58%
High	15	30%
Critical	3	6%

Note: Total non-compliant regulations N = 50 of 176 applicable

32. CHO 8 (N = 6)		
Risk	n	%
Low	9	26%
Moderate	15	43%
High	11	31%
Critical	0	0%

Note: Total non-compliant regulations N = 35 of 177 applicable

35. Independent (N = 6)		
Risk	n	%
Low	8	31%
Moderate	12	46%
High	6	23%
Critical	0	0%

Note: Total non-compliant regulations N = 26 of 175 applicable

Appendix 4

Enforcement

Table 1: Enforcement Actions by Area of Non-Compliance 2016

Area of non-compliance	Specific non-compliance	Number
Breach of Regulation	Inadequate Privacy	4
	Insufficient Staffing	4
	Inadequate individual care planning	1
	Inadequate therapeutic services	3
	Inadequate risk management procedures	2
	Inappropriate medication practices	1
	Unacceptable cleanliness	1
Breach of Rule	Seclusion facilities	1
	Seclusion practices	2
Non-adherence to Code of Practice	Inappropriate child admission	1
Breach of the 2001 Act	Inadequate capacity assessment	7
	No consent form	1
	Inadequate form	4
Breach of Condition	Individual care planning	2
	Staff training	1
	Resident transfers	1
Ongoing Non-Compliance	Unacceptable CAPA plans	7
	Ongoing regulatory breach	2
Serious Reportable Event	Serious reportable event	5

Appendix 5

Reporting independently on the quality and safety of services: Child admissions

Figure 1:
Child admissions by age and unit type. 2016. Percentages

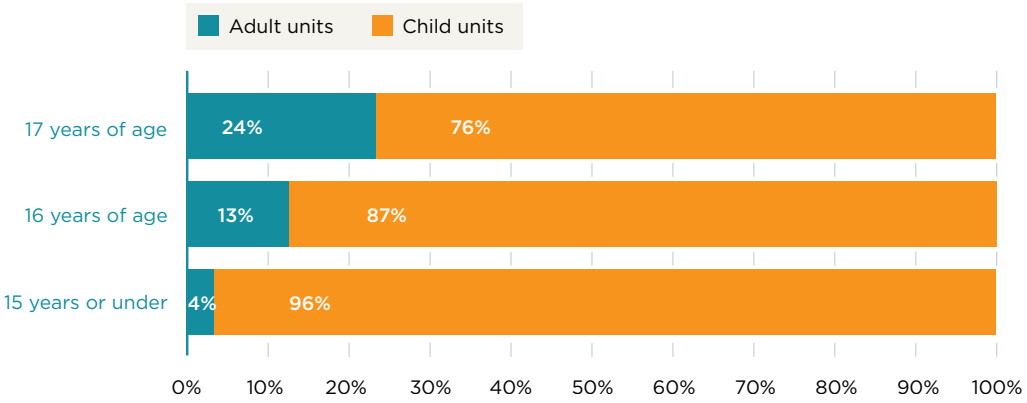


Figure 2:
Child admissions. Average duration of admission by unit type. 2014-2016. Number of days

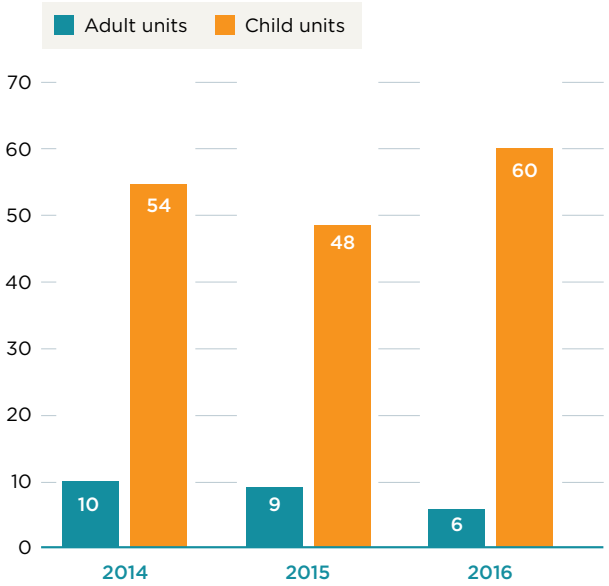


Table 1:
Child admissions to adult units by CHO. Adult units. Admissions. 2016. Numbers

CHO	Number of adult units	Number of child admissions
CHO 1	3	4
CHO 2	1	1
CHO 3	2	4
CHO 4	2	12
CHO 5	2	10
CHO 6	1	2
CHO 7	2	6
CHO 8	3	22
CHO 9	3	7
Total	19	68

Table 2:
Child Units. Primary catchment area. Registered beds. Operational beds. Admissions to child units and adult units in the primary catchment area. 2016.

		Numbers				
Child unit	Primary Catchment Area(s) by CHO[a]	Registered beds	Operational beds	Admissions to child unit	Admissions to adult units in the primary catchment area	Adult units in the primary catchment area that had child admissions
Adolescent In-patient Unit, St Vincent's Hospital	CHO 1 partial (Cavan/Monaghan) CHO 8 partial (Louth and Meath) CHO 9	12	12	66	15	6
Child & Adolescent Mental Health In-patient Unit, Merlin Park University Hospital	CHO 1 partial (Donegal and Sligo/Leitrim) CHO 2 CHO 3	20	20	95	8	5
Eist Linn Child & Adolescent In-patient Unit	CHO 4 CHO 5	20	12	40	22	4
Linn Dara Child & Adolescent Mental Health In-patient Unit, Cherry Orchard	CHO 6 CHO 7 CHO 8 partial (Laois/Offaly and Longford/Westmeath)	24	22	110	23	4
Ginesa Suite, St John of God Hospital[b]	Independent Sector – national service	12	12	56	n/a	n/a
Willow Grove Adolescent Unit, St Patrick's University Hospital	Independent Sector – national service	14	14	74	n/a	n/a
Totals		**102**	**92**	**441**	**68**	**19**

a: Child and Adolescent Mental Health Services Standard Operating Procedure. Health Service Executive, 2015.

b: Ginesa Suite is a 12-bed CAMHS unit in St John of God Hospital which is a registered approved centre.

Table 2 shows there were ninety-two designated child beds in operation in 2016 (ten less than the 102 registered child beds). Sixty-six beds were provided by four HSE child units and 26 beds were in two child units operated by independent service providers. The HSE child units provided four regional services each covering a number of HSE Community Health Organisations (CHOs) with CHO 1 and CHO 8 split across multiple child units.

The figures show that for over half of child admissions to adult units 'no age appropriate bed available' was indicated in the reasons for the admission. However, reported bed occupancy for the four HSE child units suggests there were child beds available during the year.

Figure 3:
Average monthly bed-occupancy. HSE child units. 2016. Percentages

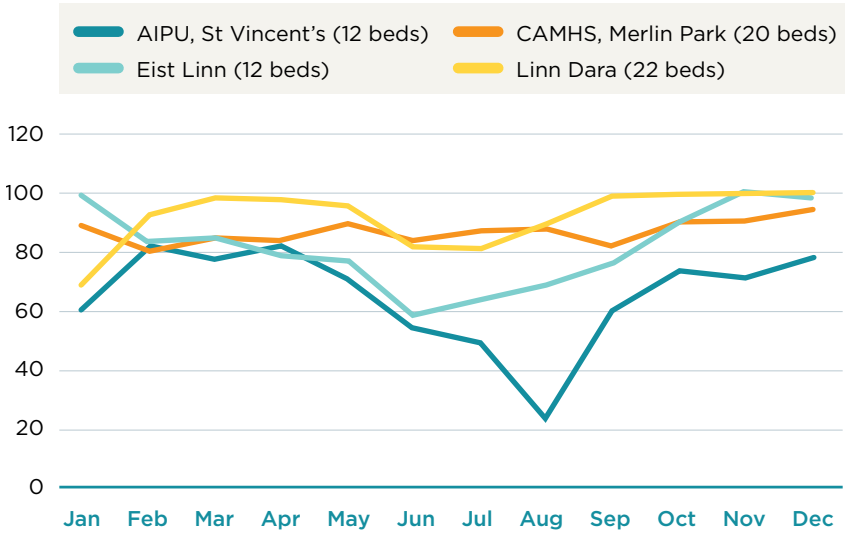
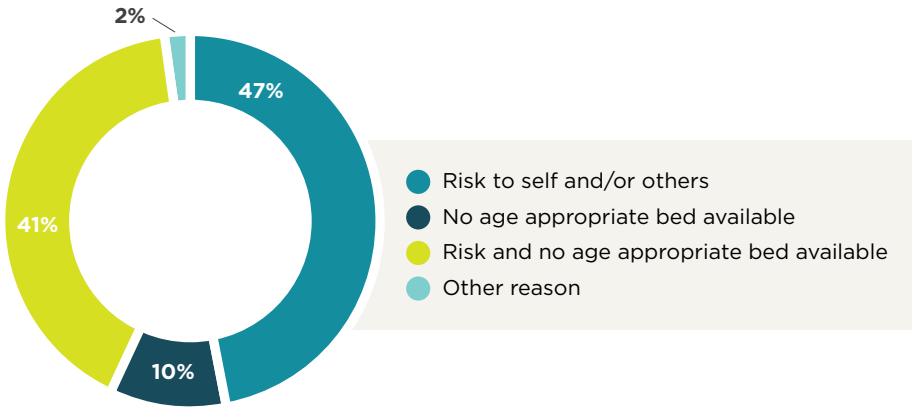


Figure 4:
Child admissions to adult units.
Reason for admission. 2016. Percentages



Appendix 6

Reporting independently on the quality and safety of services: Notification of deaths

The figure shows that there were 18 were sudden, unexplained deaths of residents of approved centres in 2016. Ten occurred when the person was on approved leave or absent without leave from an approved centre, seven occurred in an approved centre and one occurred when a person was attending a medical appointment outside the approved centre.

Figure 1:
Service type and expected or unexpected death. 2016. Percentages

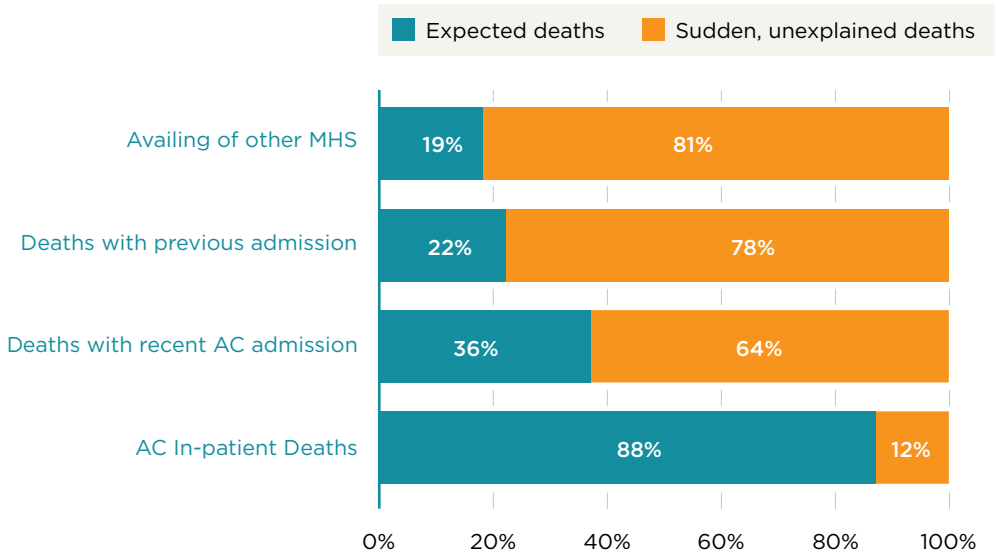
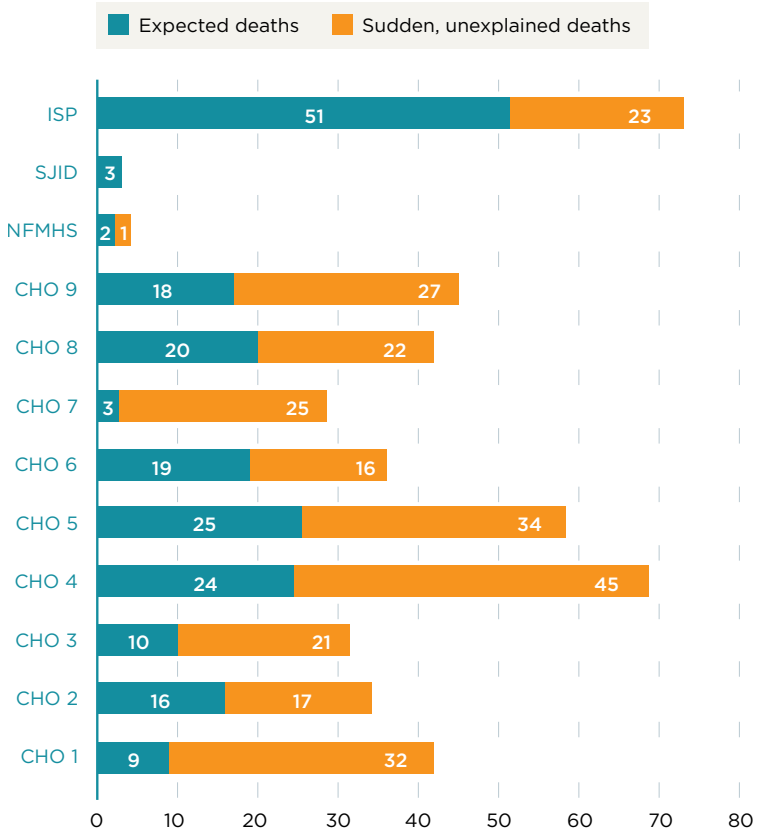


Table 1:
Deaths by service provider and service type reported. 2016. Numbers.

Service Type					
Service Provider	**AC In-patient Deaths**	**Deaths with recent AC admission**	**Deaths with previous AC admission**	**Availing of Other MHS**	**Total**
CHO 1	7	1	1	32	**41**
CHO 2	8	5	2	18	**33**
CHO 3	5	3	1	22	**31**
CHO 4	17	7	1	44	**69**
CHO 5	14	2	1	42	**59**
CHO 6	15	1	0	19	**35**
CHO 7	1	3	1	23	**28**
CHO 8	18	3	0	21	**42**
CHO 9	11	1	1	32	**45**
NFMHS	2	0	0	1	**3**
SJID	3	0	0	0	**3**
ISP	51	13	1	9	**74**
Total	**152**	**39**	**9**	**263**	**463**

The table provides a breakdown of the total death notifications by service provider and the service type reported on the death notification form.

Figure 2:
Type of death by service provider



The figure shows a breakdown of expected deaths versus sudden, unexplained deaths in each of the nine CHOs, St Jospeh's Intellectual Disability Service (SJID), the National Forensic Mental Health Service (NFMHS) and Independent Service Providers.

Appendix 7

Mental Health Commission Members and Commission Committees

Mental Health Commission Members (April 2012 – April 2017) (position at time of appointment)

Mr. John Saunders
Chairman
Director, Shine

Dr. Mary O'Hanlon
Consultant Psychiatrist Health Service Executive Dublin Mid-Leinster

Dr. Maeve Doyle
Consultant Child and Adolescent Psychiatrist Health Service Executive Dublin North East

Dr. Mary Keys
Lecturer
NUI Galway

Dr. Michael Byrne
Principal Psychology Manager, Health Service Executive West

Dr. Xavier Flanagan
General Practitioner
Clane, Co. Kildare

Mr. John Redican
National Executive Officer
National Service User Executive (NSUE)

Ms. Yvonne O'Neill
Head of Planning, Performance and Programme Management
HSE Mental Health Services

Mr. Ned Kelly
Director of Nursing
Health Service Executive South

Ms. Catherine O'Rorke
Director of Nursing
Health Service Executive
Dublin North East

Ms. Colette Nolan
Chief Executive Officer
Irish Advocacy Network

Ms. Patricia O'Sullivan Lacy
Barrister-at-Law

Ms. Pauline Gill
Principal Social Worker
Health Service Executive
National Forensic Mental Health Service

Mental Health Commission Members Attendance at meetings 2016

MEMBER	Jan 22	Mar 15	Apr 1	May 19/20	Jun 17	Jul 22	Sep 23	Oct 21	Nov 18	Dec 9	Total
Dr Michael Byrne	•	•	•	•	•	•	•	•	•	•	10/10
Dr Maeve Doyle	•	•	•	•		•	•	•	•	•	9/10
Dr Xavier Flanagan	•		•	•	•	•	•	•	•	•	9/10
Ms Pauline Gill	•			•		•	•	•	•	•	7/10
Dr Mary O'Hanlon	•	•	•	•	•		•	•	•	•	9/10
Mr Ned Kelly	•	•	•	•	•	•	•		•	•	9/10
Dr Mary Keys	•	•	•		•	•	•			•	7/10
Ms Colette Nolan		•		•	•		•	•		•	6/10
Ms. Yvonne O'Neill	•	•	•	•	•		•	•	•		8/10
Ms Catherine O'Rorke	•	•	•	•	•	•	•	•	•	•	10/10
Ms Patricia O'Sullivan Lacy		•	•	•	•	•	•		•	•	8/10
Mr John Redican											0/10
Mr John Saunders	•	•	•	•	•		•	•	•	•	9/10

Mental Health Commission Committees

The three standing Committees in the Commission during 2016 were the Audit Committee, Governance Advisory Committee and Legislation Committee.

Audit Committee 2016

Membership of the Audit Committee is made up of Commission Members (CM) and External Members (EM).

Ms. Patricia O'Sullivan Lacy (Chair) (CM), Mr. Joseph Campbell (EM), Mr. Ned Kelly (CM), Ms. Catherine O'Rorke (CM), Ms. Pauline Gill (CM), Mr. John Redican (CM), Ms. Noreen Fahy*(EM), Ms. Ciara Lynch** (EM).

Audit Committee Meetings 2016

Audit Committee Member	January	March	September	December	Total Meetings
Mr. Joseph Campbell			•	•	2/4
Ms. Patricia O'Sullivan Lacy	•	•	•		3/4
Ms. Noreen Fahy*	•		•	•	3/4
Mr. Ned Kelly	•	•	•	•	4/4
Ms. Catherine O'Rorke	•			•	2/4
Ms. Pauline Gill		•	•	•	3/4
Ms. Ciara Lynch				•	1/1
Mr. John Redican					0/4

*Ms. Noreen Fahy resigned from the Committee in December 2016

**Ms. Ciara Lynch was appointed to the Committee in December 2016

Legislation Committee 2016

Membership of the Legislation Committee is made up of Commission Members (CM) and Executive (E).

Dr. Mary Keys (Chair) (CM), Mr. Ned Kelly (CM), Ms. Patricia O'Sullivan Lacy (CM), Ms. Pauline Gill (CM), Dr. Maeve Doyle (CM),

Ms. Patricia Gilheaney (E), Mr. David Hickey (E), Ms. Marina Duffy (E).

Governance Advisory Committee 2016

Membership of the Governance Advisory Committee is made up of Commission Members, External Members (EM) and Executive (E).

Mr. John Saunders (CM), Dr. Xavier Flanagan (CM), Ms. Yvonne O'Neill (CM), Ms. Colette Nolan (CM), Mr. Moling Ryan (EM), Ms. Patricia Gilheaney (E)

Mental Health Commission Senior Management Team

- Ms. Patricia Gilheaney - Chief Executive
- Dr Susan Finnerty – Inspector of Mental Health Services
- Ms. Rosemary Smyth – Director Standards & Quality Assurance and Director Training & Development
- Mr. Ray Mooney – Director Corporate Services
- Mr. David Hickey – Director Mental Health Tribunals and Legal Affairs to September 2016.
- Dr Susan Finnerty (MCRN 009711) and Dr Fionnuala O'Loughin (MCRN 008108) shared Acting Inspector of Mental Health Services to April
- Dr Susan Finnerty (MCRN 009711) Inspector of Mental Health Services from May

Appendix 8

MHC Statutory Reporting Requirements outside of Parent Legislation

- Freedom of Information Act 2014
- Data Protection Act 1998 & Data Protection (Amendment) Act 2003
- Protected Disclosures Act 2014, Part 14 Health Act 2007
- Safety, Health & Welfare at work Act, 2005
- Prompt Payments Act 1997
- Disability Act 2005
- Maastricht Returns
- Energy Reporting (SEAI)

Mental Health Commission

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